DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: ETLH Facility ID: 00758

		10 22 00			I BOW BINDENCI		1 delinty 12. 00750				
MEDICARE/MEDICAID PROVIDER (L1) 245304	R NO.	3. NAME AND AI (L3) ANGELS C				4. TYPE OF ACT	ION: <u>7 (</u> L8)				
2.STATE VENDOR OR MEDICAID NO	2	(L4) 300 NORTH				1. Initial	2. Recertification				
(L2) 908108900	<i>.</i>	(L5) CANNON F.			(L6) 55009	3. Termination 5. Validation	4. CHOW 6. Complaint				
5. EFFECTIVE DATE CHANGE OF O	WNERSHIP	7. PROVIDER/SU		GORY	<u>02</u> (L7)	7. On-Site Visit	9. Other				
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey After Complaint					
6. DATE OF SURVEY 2/13/2		02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR ENDING DATE: (L35)					
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/III		12/31					
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31					
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	Y IS CERTIFIED	AS:		1					
From (a):		X A. In Complia	ince With		And/Or Approved Waivers Of	The Following Require	ments:				
To (b):			equirements be Based On:		2. Technical Personnel						
12.Total Facility Beds	89 (L18)	•	cceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural SN	7. Medical I					
12. Total Facility Beds	69 (E10)	1. 71	ecceptable 1 OC		5. Life Safety Code	9. Beds/Roo					
13.Total Certified Beds	89 (L17)		npliance with Prog ents and/or Appli			(L12)					
14. LTC CERTIFIED BED BREAKDOV	VN				15. FACILITY MEETS						
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)					
89	17.5111	ici	пр		1001 (c) (1) 01 1001 (j) (1).	(-)					
(L37) (L38)	(L39)	(L42)	(L43)								
16. STATE SURVEY AGENCY REMA	RKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION 1	DATE):							
See Attached Remarks											
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	V Δ PPR Ω VΔ I	Date:				
	**		22/12/2014								
Marietta Lee, HFE NE	11		03/13/2014	(L19)	Kamala Fiske-Downing,	Enforcement Spe	<u>cialis</u> t 05/16/2014 _(L20)				
PAR	T II - TO BE	COMPLETED I	BY HCFA RE	EGIONA	L OFFICE OR SINGLE S	STATE AGENCY					
19. DETERMINATION OF ELIGIBILITY	ГҮ		IPLIANCE WITH	H CIVIL	21. 1. Statement of Financial Solvency (HCFA-2572)						
X 1. Facility is Eligible to Pa	rticipate	RIGHTS ACT:			Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above :						
2. Facility is not Eligible					3.						
	(L21)										
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	·:	(L30)				
OF PARTICIPATION	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 00	<u>0</u> <u>involu</u>	JNTARY				
02/01/1986					01-Merger, Closure	05-Fail t	Meet Health/Safety				
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	sement 06-Fail t	o Meet Agreement				
25. LTC EXTENSION DATE:	27. ALTERNATI	IVE SANCTIONS			03-Risk of Involuntary Termination	on OTHER					
	A. Suspensio	n of Admissions:			04-Other Reason for Withdrawal	· · · · · · · · · · · · · · · · · · ·	der Status Change				
(1.27)			(L44)			00-Activ	re				
(L27)	B. Rescind S	uspension Date:									
			(L45)								
28. TERMINATION DATE:	29	9. INTERMEDIARY	/CARRIER NO.		30. REMARKS						
		03001									
	(L28)			(L31)							
31. RO RECEIPT OF CMS-1539	30	2. DETERMINATION	N OF APPROVAL	DATE							
The reservation of the rest	5.	02/28/2014	. J. III I KO ML								
	(L32)	V_, _U, _U1T		(L33)	DETERMINATION APP	ROVAL					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART L. TO BE COMPLETED BY THE STATE SUBVEY A GENCY

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY
Facility ID: 00758

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN-24-5304

Minnesota Department of Health completed a second Post Certification Revisit (PCR) on February 13, 2014. Based on the PCRs, it has been determined that the facility had achieved substantial compliance pursuant to the November 8, 2013 standard survey as of

February 13, 2014. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective February 13, 2014.

Mandatory denial of payment for new Medicare and Medicaid admissions, effective February 16, 2014, is rescinded. (42 CFR 488.417 (b))

The NATCEP prohibition is rescinded. Please refer to the CMS 2567b.



Protecting, Maintaining and Improving the Health of Minnesotans

March 13, 2014

Ms. Kristina Umberger, Administrator Angels Care Center 300 North Dow Street Cannon Falls, Minnesota 55009

RE: Project Number S5304023

Dear Mr. Buechner:

On January 27, 2014, we informed you that the following enforcement remedies were being imposed:

- State Monitoring effective February 14, 2014. (42 CFR 488.422)
- Mandatory denial of payment for new Medicare and Medicaid admissions effective February 16, 2014. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for a standard survey completed on November 8, 2013, that included an investigation of complaint number H5304018, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on January 3, 2014. The most serious deficiencies at the time of the revisit were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On February 13, 2014, the Minnesota Department of Health completed a second PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on January 3, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 8, 2014. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on February 13, 2014 as of February 13, 2014. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective February 13, 2014.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of January 27, 2014. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

Angels Care Center March 13, 2014 Page 2

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective February 16, 2014, is rescinded. (42 CFR 488.417 (b))

In our letter of January 27, 2014, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 16, 2014, due to denial of payment for new admissions. Since your facility attained substantial compliance on February 13, 2014, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Kumalu Fiske Downing

Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health

Telephone: (651) 201-4112

Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

	State Form: Revisit Report										
(Y1)	Provider / Supplier / CLIA / Identification Number 00758	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 2/13/2014							
Name	e of Facility		Street Address, City, State, Zip Code								
A۱	IGELS CARE CENTER		300 NORTH DOW STREET CANNON FALLS, MN 55009								

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date	(Y4)	Item	(Y5)	Date
								21980 MN St. Statute 626	
ID Prefix Reg. #		Correction Completed 02/13/2014 Sul	ID Prefix		Correction Completed		ID Prefix		Correction Completed
Reg. #		Correction Completed	Reg. #				Dog #		
ID Prefix Reg. # LSC		Correction Completed	Reg. #		Correction Completed		Reg. #		
ID Prefix Reg. #		Correction Completed	ID Prefix Reg. #		Correction Completed				
Reviewed E State Agent Reviewed E CMS RO	GN/KF	D	Date: 03/13/20	Signature of Sur Signature of Sur	1542	25		Dat Dat	02/13/2014
Followup to Survey Completed on: 11/8/2013				Check for any Uncor Uncorrected Defic					



Protecting, Maintaining and Improving the Health of Minnesotans

NOTICE OF TOTAL AMOUNT OF ASSESSMENT FOR NURSING HOMES

March 13, 2014

Ms. Kristina Umberger, Administrator Angels Care Center 300 North Dow Street Cannon Falls, Minnesota 55009

RE: Project Number S5304023

Dear Ms. Umberger:

On February 13, 2014 a Notice of Assessment for Noncompliance with Correction Orders was issued to the above facility. That Notice, which was received by the facility on February 13, 2014, imposed a daily fine in the amount of \$700.00.

On February 13, 2014, a written notification was received by the Department stating that the violation(s) had been corrected. A re-inspection was held on February 13, 2014 and it was determined that compliance with the licensing rules was attained. A copy of the State Form: Revisit Report from this visit is attached.

Therefore, the total amount of the assessment is \$1001.60. In accordance with Minnesota Statutes, section 144A.10, subdivision 7, the costs of the re-inspection, totaling \$301.60, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Commissioner of Finance, Treasury Division, in the amount of \$1001.60 within 15 days of the receipt of this notice. That check should be forwarded to the Department of Health, Division of Compliance Monitoring, 85 East Seventh Place, Suite 220, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

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.

Angels Care Center March 13, 2014 Page 2

Sincerely,

Kamala Fiske Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health

Telephone: (651) 201-4112

Fax: (651) 215-9697

cc: Licensing and Certification File

Shellae Dietrich, Licensing and Certification Program

Penalty Assessment Deposit Staff

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245304	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 2/13/2014
Name of Facility		Street Address, City, State, Zip Code	
ANGELS CARE CENTER		300 NORTH DOW STREET CANNON FALLS, MN 55009	

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

(Y4) Item		(Y5)	Date	(Y4) Item		(Y5)	Date	(Y4)	Item	(Y5)	Date
ID Prefix	F0225	С	orrection ompleted 2/13/2014	ID Prefix	F0226		Correction Completed 02/13/2014		ID Prefix	F0318		Correction Completed 02/13/2014
	483.13(c)(1)(ii)-(iii		-		483.13(c)		-			483.25(e)(2)		<u> </u>
ID Prefix	F0323	С	orrection ompleted 2/13/2014	ID Prefix	F0371		Correction Completed 02/13/2014		ID Prefix			Correction Completed
	483.25(h)		-, 10, 2014		483.35(i)		-					
Reg. #		C	orrection ompleted	Reg. #			Correction Completed					Correction Completed
ID Prefix Reg. # LSC		C	orrection ompleted	Reg. #			Correction Completed					Correction Completed
ID Prefix Reg. #		C C	orrection ompleted	ID Prefix Reg. #			Correction Completed					Correction Completed
Reviewed I	By Rev	iewed B	у	Date:	Signatu	re of Su	rveyor:				Date:	
State Agen Reviewed I CMS RO	-	iewed B	GN/KFD y	03/13/201 Date:	4 Signatu	re of Su	rveyor:	154	125		Date:	02/13/2014
Followup t	to Survey Comple 11/8/201									Summary of the Facility?	YES	NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: ETLH
Facility ID: 00758

	IANI I -	TO BE COMIT		IIIE SIA	IE SURVEI AGENCI		racinty iD. 00736
MEDICARE/MEDICAID PROVIDER (L1) 245304 2.STATE VENDOR OR MEDICAID NO (L2) 908108900		3. NAME AND AI (L3) ANGELS C. (L4) 300 NORTH (L5) CANNON F.	ARE CENTE	R	(L6) 55009	4. TYPE OF ACTI 1. Initial 3. Termination 5. Validation	ON: 7 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF O		7. PROVIDER/SU 01 Hospital	JPPLIER CATEO	09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey Aft	9. Other er Complaint
6. DATE OF SURVEY 01/03/. 8. ACCREDITATION STATUS: 0 Unaccredited 1 TIC 2 AOA 3 Other	(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR END 12/31	DING DATE: (L35)
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	Y IS CERTIFIED	AS:			
From (a):		A. In Complia			And/Or Approved Waivers Of	- -	
To (b):			lequirements be Based On:		2. Technical Personnel3. 24 Hour RN	6. Scope of S 7. Medical D	
12.Total Facility Beds	89 (L18)	1. A	acceptable POC		4. 7-Day RN (Rural SN 5. Life Safety Code		om Size
13.Total Certified Beds	89 (L17)	X B. Not in Con Requirem	mpliance with Pro ents and/or Appl			(L12)	-
14. LTC CERTIFIED BED BREAKDOV	/N				15. FACILITY MEETS		
18 SNF 18/19 SNF 89	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REMA	RKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):			
See Attached Remarks							
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:
Marietta Lee HFE	NE II	12	2/24/2014	(L19)	K <u>amala Fiske-Downing,</u>	Enforcement Spe	<u>cialis</u> t 05/16/2014 (L20)
PAR	T II - TO BE	COMPLETED I	BY HCFA RI	EGIONA	L OFFICE OR SINGLE S	STATE AGENCY	
DETERMINATION OF ELIGIBILE X 1. Facility is Eligible to Pa 2. Facility is not Eligible			MPLIANCE WIT HTS ACT:	H CIVIL	21. 1. Statement of Fina2. Ownership/Control3. Both of the Above	ol Interest Disclosure Str	
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREE	MENT	26. TERMINATION ACTION	:	(L30)
OF PARTICIPATION 02/01/1986	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 00 01-Merger, Closure		UNTARY Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	ement 06-Fail to	Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	OTHER	
	A. Suspension	n of Admissions:	(L44)		04-Other Reason for Withdrawal	07-Provi 00-Activ	der Status Change
(L27)	B. Rescind S	uspension Date:	(L44)			oo neav	•
28. TERMINATION DATE:	29	9. INTERMEDIARY			30. REMARKS		
		03001					
	(L28)	03001		(L31)			
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	N OF APPROVAL	L DATE			
	(L32)	02/28/2014		(L33)	DETERMINATION APP	ROVAL	

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00758

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN-24-5304

At the time of the Post Certification Revisit (PCR) completed January 3, 2014 the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), The deficiencies not corrected are as follows:

F0318 -- S/S: D -- 483.25(e)(2) -- Increase/prevent Decrease In Range Of Motion

F0323 -- S/S: D -- 483.25(h) -- Free Of Accident Hazards/supervision/devices

F0371 -- S/S: F -- 483.35(i) -- Food Procure, Store/prepare/serve - Sanitary

In addition, at the time of this revisit, we identified the following deficiencies:

F0225 -- S/S: D -- 483.13(c)(1)(ii)-(iii), (c)(2) - (4) -- Investigate/report Allegations/individuals

F0226 -- S/S: D -- 483.13(c) -- Develop/implment Abuse/neglect, Etc Policies.

An addition Post Certification Revisit will follow. Please refer to the CMS 2567 and 2567b the along with the facility's plan of correction.



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7982

January 27, 2014

Mr. Rick Buechner, Administrator Angels Care Center 300 North Dow Street Cannon Falls, Minnesota 55009

RE: Project Number S5304023 and Complaint Number H5304018

Dear Mr. Buechner:

On December 11, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 8, 2013 that included an investigation of complaint number H5304018. 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 January 3, 2014, the Minnesota Department of Health and on January 17, 2014, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 8, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of Decemer 18, 2013. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on November 8, 2013. The deficiencies not corrected are as follows:

- F0318 -- S/S: D -- 483.25(e)(2) -- Increase/prevent Decrease In Range Of Motion
- F0323 -- S/S: D -- 483.25(h) -- Free Of Accident Hazards/supervision/devices
- F0371 -- S/S: F -- 483.35(i) -- Food Procure, Store/prepare/serve Sanitary

In addition, at the time of this revisit, we identified the following deficiencyies:

- F0225 -- S/S: D -- 483.13(c)(1)(ii)-(iii), (c)(2) (4) -- Investigate/report Allegations/individuals
- F0226 -- S/S: D -- 483.13(c) -- Develop/implment Abuse/neglect, Etc Policies

The most serious deficiencies in your facility were found 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.

Angels Care Center January 27, 2014 Page 2

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

• State Monitoring effective February 1, 2014. (42 CFR 488.422)

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective February 16, 2014 (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective February 16, 2014. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 16, 2014. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Angels Care Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Program or Competency Evaluation Programs for two years effective February 16, 2014. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

A copy of the Statement of Deficiencies (CMS-2567) and the Post Certification Revisit Form (CMS-2567B) from this visit are enclosed.

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt

of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Angels Care Center January 27, 2014 Page 3

> Department of Health and Human Services Departmental Appeals Board, MS 6132 Civil Remedies Division Attention: Karen R. Robinson, Director 330 Independence Avenue, SW Cohen Building, Room G-644 Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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:

Gary Nederhoff, Unit Supervisor Minnesota Department of Health 18 Wood Lake Drive Southeast Rochester, Minnesota 55904-5506

Telephone: (507) 206-2731

Fax: (507) 206-2711

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its

effectiveness. The plan of correction is integrated into the quality assurance system;

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

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

• 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 your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

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 May 8, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by

Angels Care Center January 27, 2014 Page 5

the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Enforcement Specialist

Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health

Telephone: (651) 201-4124

Dre Klegge

Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

State Form: Revisit Report									
(Y1)	Provider / Supplier / CLIA / Identification Number 00758	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 1/3/2014					
Name	e of Facility		Street Address, City, State, Zip Code						
A١	IGELS CARE CENTER		300 NORTH DOW STREET						

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

Y4) Item		(Y5)	Date	(Y4) Item	(Y5)	Date	(Y4) Item		(Y5)	Date
		_	orrection			Correction				Correction
ID Prefix	20565		ompleted 2/18/2013	ID Prefix		Completed 12/18/2013	ID Prefix	20800		Completed 12/18/2013
Reg. # LSC		58.0405 Subp		<u> </u>	MN Rule 4658.0405 Sub		Reg. #	MN Rule 465		
		0	Al			2				0
ID Duefis	00000	C	orrection ompleted	ID Duefic	(Correction Completed 12/18/2013	ID Duefi	. 01400		Correction Completed
ID Prefix		58.0525 Subp	2/18/2013	ID Prefix	MN Rule 4658.0800 Sub			21426 # MN St. Statu	to 1// A	12/18/2013
		30.0323 3ubp	• '	- 3	MIN Fulle 4030.0000 Sub	•		;		
		Co	orrection		(Correction				Correction
ID Prefix	21530		ompleted 2/18/2013	ID Prefix		Completed 12/18/2013	ID Prefix	21630		Completed 12/18/2013
Reg. # LSC	MN Rule 46	58.1310 A.B.C	:	Reg. # LSC	MN Rule4658.1315 Subp	5.1	Reg. #	MN Rule 465	58.1350 S	Subp.
			orrection			Correction				Correction
ID Prefix	21680		ompleted 2/18/2013	ID Prefix		Completed 12/18/2013	ID Prefix	(Completed
	MN Rule 46	58.1415 Subp	•	Reg. # LSC	MN Rule 4658.1415 Sub	p. ;	Reg. #			
		Ce	orrection			Correction				Correction
ID Prefix		C	ompleted	ID Prefix		Completed	ID Prefix	(Completed
Reg. # LSC				Reg. #			Reg. #	#		
130	·			LSC			Loc	,		
Reviewed E	' —	Reviewed B GN/AK	у	Date: 01/24/2014	Signature of Surv	/eyor:	1	9694	Date: 01/03	/2014
Reviewed E		Reviewed B	у	Date:	Signature of Surv	/eyor:			Date:	
Followup to Survey Completed on: 11/8/2013			Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility						NO	

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245304	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 1/3/2014
Name	of Facility		Street Address, City, State, Zip Code	
A٨	GELS CARE CENTER		300 NORTH DOW STREET	
			CANNON FALLS MN 55009	

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

(Y4) Item		(Y5)	Date	(Y4) Item	(YS	5) Date	(Y4)	Item		(Y5)	Date
ID Prefix		(Correction Completed 12/18/2013	ID Prefix	F0280	Correction Completed 12/18/2013		ID Prefix	F0282		Correction Completed 12/18/2013
Reg. # LSC	483.15(a)			Reg. # LSC	483.20(d)(3), 483.10(k))(2) 		Reg. # LSC	483.20(k)(3)(ii	i)	<u>_</u>
ID Prefix Reg. # LSC	F0285 483.20(m), 483.20(1	Correction Completed 12/18/2013	ID Prefix Reg. # LSC	F0312 483.25(a)(3)	Correction Completed 12/18/2013		ID Prefix Reg. # LSC	F0329 483.25(I)		Correction Completed 12/18/2013
ID Prefix Reg. # LSC	F0353 483.30(a)	(Correction Completed 12/18/2013	ID Prefix Reg. # LSC	F0373 483.35(h)	Correction Completed 12/18/2013		ID Prefix Reg. # LSC	483.60(c)		Correction Completed 12/18/2013
	F0431 483.60(b), (d), (e)	1	Correction Completed 12/18/2013		F0441 483.65	Correction Completed 12/18/2013		Reg. #	F0465 483.70(h)		Correction Completed 12/18/2013
ID Prefix Reg. # LSC			Correction Completed	Reg. #							
Reviewed I State Agen Reviewed I	cy GN/	ewed		Date: 01/24/2014 Date:	Signature of Su Signature of Su			19	9694	Date: 01/03	3/2014
	o Survey Complete				Check for any Uncorrected Def					YES	NO

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245304	(Y2) Multiple Cons A. Building B. Wing	O1 - MAIN BUILDING 01			
Name of Facility			Street Address, City, State, Zip Code		
ANGELS CARE CENTER			300 NORTH DOW STREET		
			CANNON FALLS MN 55009		

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

(Y4) Item	(Y	5) Date	(Y4) Item	(Y5)	Date	(Y4) Item	(Y:	5) Date	
ID Prefix		Correction Completed 01/08/2014	ID Prefix		Correction Completed				
Ū	NFPA 101 K0067	 	Reg. # LSC			Reg. # LSC			
Reg. #		Correction Completed	Reg. #		Correction Completed	Reg. #			
ID Prefix Reg. # LSC		Correction Completed	Reg. #		Correction Completed	Reg. #			
Reg. #		Correction Completed	Reg. #		Correction Completed	ъ "			
			Reg. #		Correction Completed				
Reviewed E	PS/AK	-	Date: 01/24/2014	Signature of Sur	veyor:	25		Pate: 01/17/2014	
Reviewed E	By Reviewe	d By	Date:	Signature of Sur	veyor:		С	Pate:	_
Followup to Survey Completed on: 11/5/2013				Check for any Uncor Uncorrected Defic			Alaa Faailia.o	YES NO	



Protecting, Maintaining and Improving the Health of Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Hand Delivered on XXXX

XX DATE XX

Mr. Rick Buechner, Administrator Angels Care Center 300 North Dow Street Cannon Falls, Minnesota 55009

Re: Project Number S5304023 and Complaint Number H5304018

Dear Mr. Buechner:

On January 3, 2014, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on November 8, 2013.

State licensing orders issued pursuant to the last survey completed on November 8, 2013 and found corrected at the time of this January 3, 2014 revisit, are listed on the attached Revisit Report Form.

State licensing orders issued pursuant to the last survey completed on November 8, 2013, found not corrected at the time of this January 3, 2014 revisit and subject to penalty assessment are as follows:

20895 -- S/S: -- MN Rule 4658.0525 Subp. 2.B -- Rehab - Range Of Motion - \$350.00 21015 -- S/S: -- MN Rule 4658.0610 Subp. 7 -- Dietary Staff Requirements-Sanitary Condition - \$350.00

The details of the violations noted at the time of this revisit completed on January 3, 2014 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, sign and date this form or return it to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, section 144A.10, you will be assessed an amount of \$700.00 per day beginning on the day you receive this notice.

The fines shall accumulate daily until written notification from the nursing home is received by the Department stating that the orders have been corrected. This written notification shall be mailed or delivered to the Department at the address below or to, Minnesota Department of Health, Licensing and Certification Program, Division of Compliance Monitoring, 18 Wood Lake Dr Se Rochester, Mn 55904.

Angels Care Center January 27, 2014 Page 2

When the Department receives notification that the orders are corrected, a reinspection will be conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Mary Henderson, Minnesota Department of Health, Licensing and Certification Program, Division of Compliance Monitoring, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

Also, at the time of this reinspection completed on January 3, 2014 additional violations were cited as follows:

21980 -- S/S: -- MN St. Statute 626.557 Subd. 3 -- Reporting - Maltreatment Of Vulnerable Adults 21985 -- S/S: -- MN St. Statute 626.557 Subd. 3a -- Reporting - Maltreatment Of Vulnerable Adults

They are delineated on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Only the ID Prefix Tag in the left hand column without brackets will identify these licensing orders. It is not necessary to develop a plan of correction, however, when all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 18 Wood Lake Dr Se Rochester, Mn 55904. 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.

Sincerely,

Anne Kleppe, Enforcement Specialist Licensing and Certification Program

Division of Compliance Monitoring

Minnesota Department of Health

Done Klegepe

Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

Gary Nederhoff, Rochester District Office Survey and Review Unit

Shellae Dietrich, Licensing and Certification Program

Penalty Assessment Deposit Staff

PRINTED: 01/24/2014 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION AP 2007 G	(X3) DATE SURVEY COMPLETED	
		245304	B. WING _	Rochester	0	R 1/ 03/2014
ł	PROVIDER OR SUPPLIER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009	· ··	1700/2014
(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENT	S	{F 000			
	January 2, 3, 2014 to uncorrected for the f F323, and F371. Ne F225 and F226.	cation revisit to the facility on he facility was found to be ollowing deficiencies: F318, w deficiencies were cited at ation/s had been completed				
SS=D	at the time of the sta on 11/08/13 and duri revisit completed on	ndard recertification survey ng the post certification January 2, 3, 2014 the had been corrected at F241, c)(2) - (4) DRT	F 225	F225		
	been found guilty of a mistreating residents had a finding entered registry concerning a of residents or misap and report any knowlecourt of law against a indicate unfitness for	employ individuals who have abusing, neglecting, or by a court of law; or have I into the State nurse aide buse, neglect, mistreatment propriation of their property; edge it has of actions by a in employee, which would service as a nurse aide or ne State nurse aide registry s.		The facility will ensure that the an abuse prevention plan in plan and that all alleged violations a fully investigated and prevent potential for further abuse bas on the facility policy and proce Resident #6 has had incidents overbal abuse by a family member proceed.	ace are the ed dure. of	
i i r i t	nvolving mistreatmer ncluding injuries of un misappropriation of remmediately to the ad oother officials in acc	nknown source and esident property are reported ministrator of the facility and cordance with State law rocedures (including to the	2/5/14	reported, investigated and actitaken per facility policy. Reside care plan was reviewed and updated.	on nts	
BORATORY E	VIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGN	ATURE	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.

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDÉR/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION ZUTT	(X3) DATE SURVEY COMPLETED
				ivin Dept of Health Rochester	R
		245304	B. WING		01/03/2014
	PROVIDER OR SUPPLIER S CARE CENTER		3	STREET ADDRESS, CITY, STATE, ZIP CODE 800 NORTH DOW STREET CANNON FALLS, MN 55009	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F.225	The facility must have violations are thoroup revent further poter investigation is in present the control of t	ve evidence that all alleged ighly investigated, and must nitial abuse while the ogress.	.F 225	reviewed and appropriate. All will be educated on the facility Resident Protection policy. Fa has implemented a tracking log	staff , cility
	to the administrator representative and to with State law (include certification agency) incident, and if the a	estigations must be reported or his designated o other officials in accordance ding to the State survey and within 5 working days of the lleged violation is verified re action must be taken.		incidents to monitor proper documentation and reporting. The facility Social Worker or designee will interview 3 reside weekly to see if they have condand ensure follow-up is complete.	ents cerns
	by: Based on observation review, the facility far allegations of verbal director/administrato agency immediately investigation and imprevent further iniced protect the resident vocaducted for 1 of 1 reviewed for allegation potential to affect allegation for the received continue without thorough investing place to prevent further in place to	on, interview and document illed to immediately report abuse to the executive r nor to the designated state nor complete a thurough element interventions to enets from reoccuring and while the investigation was resident (R6) who was ons of abuse. This had the 58 residents in the facility. In additional to the investigation was resident to the investigation was resident to the facility. In additional to the facility of the resident with the facility of the		and also monitor that the procedure is being followed. Administrator or designee will conduct weekly audits of at lea staff to determine knowledge of the facility's policy and procedu for reporting and investigation resident incidents. Immediate education of staff will be completed if problems or inconsistencies are found. Results of audits will be communicated to the QA	st 3 of ure of

		FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION LB . 2014	(X3) DAT	E SURVEY IPLETED
			245304	B. WING		MN Dept of Health Rochester	1	R 03/2014
		PROVIDER OR SUPPLIER CARE CENTER		·	- 3	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NORTH DOW STREET CANNON FALLS, MN 55009		
PR	4) ID EFIX AG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F		wheelchair in the lol were also located in immediately reporte coordinator who wa this unit and had be from R6. Nurse coordinator the talked to R6 in this ron 1/3/14 at 2:20 p. social worker (SW) F-A and R6, SW stadirector had talked to way F-A talked to R6 also added when shoot felt it was a probe R6 was identified on Resident Information diagnosis that included congestive heart fail R6 was identified by Minimum Data Set (10/23/13, to have intextensive assistance daily living, and had motion functional limburing interview on executive director ar aware of F-A's verbal Although executive chad talked with R6 averified the facility la investigation of the bethey had not reporter	t time revealed R6 sat in a by and three staff members the lobby. Surveyor of the incident to the nurse is in charge of the residents on en located only a few feet ordinator had then identified made the statement to R6. Then stated F-A had often manner quite often in the past. The members of the incident with the concerning the incident with the concerning the incident with the she and the executive or R6 and F-A concerning the in a disrespected way. SW the had talked to R6, R6 had been. The facility Admission Record in form dated 8/26/10, to have the diabetes mellitus and	F 2	225	committee and action plans developed as needed. The facility will be substantial compliance with the standard indicated by 2/8/14.		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	69/7	E SURVEY IPLETED
		245304	B. WING	MOChester -	R 03/2014
	PROVIDER OR SUPPLIER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC 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 225	executive director since port incidents of a and to complete an director verified their reported to her of veno incident reports of and F-A. During interview on stated she was not imistreatment, but the concerned about phinad not hit her. R6 facility for six years a R6 stated F-A yelled "go in one ear and of verbal abuse did not "doesn't scare her biner. R6 stated F-A stated although she "verbal" with her, shingo home and she were		F 2	25	
	Facility staff interviev	ws included the following:			
	's behavior. R-A sta spoke to R6 in a " d yells at R6 "You neve she usually reported worker or registered director, so " some	1/3/14, at 2:55 p.m., stated she was aware of F-A ated most of the time F-A isrespectful " tone, also F-A er listen to me." R-A stated this behavior to social nurse manager or executive one can deal with it." R-A I vulnerable adult number if			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	÷			. 2019	R ·	
		245304	B. WING _	MN Dant at Health	01/	03/2014
	PROVIDER OR SUPPLIER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	· (X5) COMPLETION DATE
F 225	social services or digiven any recomme when F-A treats R6 report the incident to executive director. During interview on housekeeper-A (HS aware of F-A's behavior towards Rhad occurred for the HSK-A did not get in sometimes R6 talke yelling. During interview on registered nurse (Riverbal behavior was sometimes R6 woul RN-C stated if she cwas abusive from Freport to facility soci	ge 4 rvisor to notify. R-A stated frector of nursing had not endations to R-A for what to do disrespectfully except to onurse, director of nursing or 1/3/14, at 3:05 p.m., K-A) stated they had been eavior of loud, rude and nasty 6. HSK-A stated the behavior of past 2 to 3 weeks and that envolved. HSK-A stated ded back to F-A during F-A 1/3/14, at 3:08 p.m., N)-C stated F-A, alleged igust their personality and that d talk back to family member. Sid hear something she felt had worker or the evening entails family member visited in the	F 22	5		
	from 12/18/13 to 1/2 alleged verbal abuse Document review of 10/3/13 to 1/1/14, reincidents of verbal number. Document review of revealed focus residues the staff and/or other	R6 care plan dated 11/20/13, lent was vulnerable to abuse residents related to impaired are plan goal was safety				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245304	B. WING			R 01/03/2014	
NAME OF	PROVIDER OR SUPPLIER	***************************************	<u> </u>	STRE	EET ADDRESS, CITY, STATE, ZIP CODE	1. 01/	/03/2014
ANGELS	CARE CENTER				NORTH DOW STREET INON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x .	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
	Interventions included report to staff if reside bothered by other replan lacked interventions behaviors by family. Document review of Process policy revision following: Procedur 1. Immediately up notified of an accide involving a resident, surrounding the incidinging of unknown or bruises and skin teat allegation of injury, and/or maltreatment suspicious death of includes allegations and incidents of allegations. Follow all immediate procedures for mand justice act for situation including immediate Director. 5. The Executive Diand /or Social Service Designees ensurenotifications, and involved completed with the follow-up. 6. Staff are to implet to prevent reoccurrent.	through staff intervention. ed to encourage resident to dent felt threatened or esidents and/or staff. R6 care tions for continued verbal member. facility Resident Incident ed dated 7/13, revealed the e: on witnessing or being nt, incident or altercation an investigation of the facts dent is initiated. Any fall, known origin, (including rs) medication errors, allegation of abuse, neglect self-abuse/suicide attempt, a resident, elopement (this of resident to resident abuse ged financial exploitation) will e Risk Management to resident and elder cons of alleged abuse/neglect, notification to the Executive rector, Director of Nursing the Director and IDT es that appropriate follow-up, estigation is e incident, and documents ment interventions for safetynce.	F 2	25			
	Document review of	facility					

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
·		245304	B. WING		01	R / 03/2014		
	PROVIDER OR SUPPLIER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009	. ,	700,2014		
YA4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI ((EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE		
	Resident/client/partiper Procedure revised of following: page 5: # a. Upon receiving a maltreatment, the E Director of Nursing/or designee will cook which will include constatements. b. All parties involved following-staff, residivisitors, who were proposerved the alleged interviewed by ED, Edesignee. Statemer Witness Interview Forconducted with 2 state whenever possible/a f. Identify and implication. h. The investigation consultation. h. The investigation completed and review Director/or design other officials in according to the input from approach of the will ensue to prevent as specified per page 6: #4. Reporting Page 6: #4. Reporting following page 6: #4	cipant Protection Policy and lated 12/12, directed staff the 2. Investigation: complaint of alleged D (executive director), designee and Social services rdinate an investigation, impletion of witness red including two of the ent/client/participants or otentially involved, or dincident are to be DON, Social services or its should be written on the orm. Interviews should be ff members present ppropriate. The entrement appropriate creased 1:1, psychological and written findings are wed with the Executive mated representative, and to ordance with state or the action is determined priate personnel. The entremental entremeds are processed of the entremeds of the entr	F 25	25				
la	Individuals: a. Who must report a resident/client/partic	suspected maltreatment of cipant? Any employee,						

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		(X3) DATE SURVEY COMPLETED	
•	245304		Rochester	R	
			STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET) 01/03/2014	
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECT IX (EACH CORRECTIVE ACTION SHOL	LD BE COMPLETION	_
resident/client/partic external business v who: (continued on Has knowledge a resident/client/partic has reasonable resident/client/partic b. What is the profacility/service? 1. After safegua resident/client/partic well as his/her rights supervisor immedia: Director/or designat officials in accordan contacted immediate regarding all allegati Immediate reporting mail, answering mad	cipant, family/guardian, endor or entity, or volunteer page 7) of suspected maltreatment of ticipant. cause to believe that a cipant has been maltreated. cedure for reporting within the rding the cipant (and all residents) as a report the information to the tely. The Executive ed representative (and other ce with state law) must be ely by Supervisor or reporter ons of abuse/neglect. may be reported via voice chine, or fax. Document date	F 2	225		
and time of notification Page 10: E. Definition Abuse/Mistres of injury, unreasonal intimidation, of physical harm, pain, Page 11: #5. Verbal The use of or language that willfully derogatory tel resident/client/partici within their hearing distance, regate comprehend, or disa Page 13: D. Psychological	on. ons of Abuse and Neglect: atment is the willful infliction ble confinement, or punishment with resulting or mental anguish. Abuse: al, written or gestured y includes disparaging and rms to pants or their families, or ardless of their age, ability to bility.				
	Continued From paresident/client/particexternal business who: (continued on Has knowledge a resident/client/particexternal business who: (and is the profacility/service? 1. After safeguaresident/client/particexternal business with a supervisor immediate president/client/particexternal business with a supervisor immediate regarding all allegation business with a supervisor immediate regarding all allegation business with a supervisor immediate reporting mail, answering mach and time of notification with a supervisor intimidation, on the physical harm, pain, and the particle within their hearing distance, regard comprehend, or disaverse with the particle within their hearing distance, regard comprehend, or disaverse with the particle within their hearing distance, regard comprehend, or disaverse with the particle within their hearing distance, regard comprehend, or disaverse with the particle within their hearing distance, regard comprehend, or disaverse with the particle within their hearing distance, regard comprehend, or disaverse within the particle within their hearing distance, regard comprehend, or disaverse within the particle wi	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 resident/client/participant, family/guardian, external business vendor or entity, or volunteer who: (continued on page 7) Has knowledge of suspected maltreatment of a resident/client/participant. Has reasonable cause to believe that a resident/client/participant has been maltreated. b. What is the procedure for reporting within the facility/service? 1. After safeguarding the resident/client/participant (and all residents) as well as his/her rights, report the information to the supervisor immediately. The Executive Director/or designated representative (and other officials in accordance with state law) must be contacted immediately by Supervisor or reporter regarding all allegations of abuse/neglect. Immediate reporting may be reported via voice mail, answering machine, or fax. Document date and time of notification. Page 10: E. Definitions of Abuse and Neglect: Abuse/Mistreatment is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Page 11: #5. Verbal Abuse: The use of oral, written or gestured language that willfully includes disparaging and derogatory terms to resident/client/participants or their families, or	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 resident/client/participant, family/guardian, external business vendor or entity, or volunteer who: (continued on page 7) Has knowledge of suspected maltreatment of a resident/client/participant has been maltreated. b. What is the procedure for reporting within the facility/service? 1. After safeguarding the resident/client/participant (and all residents) as well as his/her rights, report the information to the supervisor immediately. The Executive Director/or designated representative (and other officials in accordance with state law) must be contacted immediately by Supervisor or reporter regarding all allegations of abuse/neglect. Immediate reporting may be reported via voice mail, answering machine, or fax. Document date and time of notification. Page 10: E. Definitions of Abuse and Neglect: Abuse/Mistreatment is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Page 11: #5. Verbal Abuse: The use of oral, written or gestured language that willfully includes disparaging and derogatory terms to resident/client/participants or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Page 13: D. Psychological/Emotional Abuse: #6. Use of repeated or malicious oral,	The provider or supplies 245304 245304 245304 E PROVIDER OR SUPPLIER S CARE CENTER SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 7 resident/client/participant, family/guardian, external business vendor or entity, or volunteer who: (continued on page 7) Has knowledge of suspected maltreatment of a resident/client/participant has been maltreated. b. What is the procedure for reporting within the facility/service? 1. After safeguarding the resident/client/participant (and all residents) as well as his/her rights, report the information to the supervisor immediately. The Executive Director/or designated representative (and other officials in accordance with state law) must be contacted immediately by Supervisor or reporter regarding all allegations of abuse and Neglect: Abuse/Mistreatment is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish, Page 11: #5. Verbal Abuse: The use of oral, written or gestured language that willfully includes disparaging and derogatory terms to resident/client/participants or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Page 13: D. Psychological/Emotional Abuse: #6. Use of repeated or malicious oral,	SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSG IDENTIFYMS INFORMATION) Continued From page 7 resident/client/participant, family/guardian, external business vendor or entity, or volunteer who: (continued on page 7) Has knowledge of suspected maltreatment of a resident/client/participant has been maltreated. b. What is the procedure for reporting within the facility/service? 1. After safeguarding the Excelutive Director/or designated representative (and other officials in accordance with state law) must be contacted immediately by Supervisor or reporter regarding all allegations of abuse/neglect. Immediate reporting may be reported via voice mail, answering machine, or fax. Document date and time of notification. Page 10: E. Definitions of Abuse and Neglect: Abuse/Mistreatment is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Page 11: #5. Verbal Abuse: The use of oral, written or gestured language that willfully includes disparaging and derogatory terms to resident/client/participants or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Page 13: D. Psychological/Emotional Abuse: #6. Use of repeated or malicious oral,

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION ING		E SURVEY IPLETED
	·	045004				R
		245304	B. WING		<u> 01/</u>	03/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ANGELS	S CARE CENTER			300 NORTH DOW STREET		*.
				CANNON FALLS, MN 55009		,
(X4) ID	1	TEMENT OF DEFICIENCIES	D	PROVIDER'S PLAN OF CORRECTION		(X5)
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		,		DEFICIENCY)		
F 225	Continued From pa	ae 8	F 2	25		
	i	dult or the treatment of a				
	l e e e e e e e e e e e e e e e e e e e	ich would be considered by				
		e person to be disparaging,				
	derogatory, humiliat	ting, harassing, or				
	threatening.					
		·		·	. 1	
		1/3/14, at 3:45 p.m.,				
		tated F-A's verbal behaviors ing since the middle of				
		nich time F-A had moved into				
٠		director stated she was not				
		nts of F-A exhibiting verbal				
		her residents. She stated F-A				
		one time that she was aware				
		ector immediately talked to			ļ	·
		behavior. Executive director				
		o documentation of this				
		-A. Executive director stated 'Ombudsman" one time				
		of November 2013 or first				
		2013" in regards to F-A and				
		ecutive director verified there		·		
	was no documentati	ion of this conversation either.				
		tated the facility had no			·	
		ted to F-A's alleged verbal				
		e director stated the facility				
		's alleged verbal abuse by				
		nealth facility (OHFC) as this				
		ongoing. Executive director lacked a thorough investigation				
	of the ongoing allega					
		i. Executive director than said				
		f abuse of any type is to be				
	reported to her imme	ediately.				
	483.13(c) DEVELOR	P/IMPLMENT	F 22	26		
	ABUSE/NEGLECT,			·		
	<u></u>				1	
	The facility must dev	elop and implement written]	

	OF DEFICIENCIES OF CORRECTION				(X3) DATE SURVEY COMPLETED
		245304	B. WING_		R 01/03/2014
NAME OF I	PROVIDER OR SUPPLIER		<u></u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 01/00/2014
ANGELS	CARE CENTER			300 NORTH DOW STREET CANNON FALLS, MN 55009	
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F 226	Continued From pa	ge 9	F 22	F226	2/8/14
·		ures that prohibit ect, and abuse of residents on of resident property.	٠	The facility will ensure that the an abuse prevention plan in pland that all alleged violations fully investigated and prevent	lace are
	by: Based on observate review, the facility for Resident Incident Procedure which income to be immediated to initiate an implement intervent (R6) observed for withe potential to affect of a section of the section of	icipant Protection Policy and dicated allegations of abuse ately reported to the executive of the designated state agency, investigation, and failed to a tions to protect 1 of 1 resident erbal maltreatment. This had ct all 58 residents residing in excluded.		potential for further abuse ba on the facility policy and proc Resident #6 has had incidents verbal abuse by a family mem reported, investigated and ac taken per facility policy. Resid care plan was reviewed and updated. Facility policy and procedure reviewed and appropriate. All will be educated on the facility	edure. s of aber tion lents was
	R6 experienced on- from a family (F)-A eleven weeks with director notification, agency notification, investigation, and w protect R6 from one according to facility Document review o Process policy revis following: Procedur 1. Immediately up notified of an accide	rithout interventions in place to going verbal mistreatment, vulnerable adult policies. If facility Resident Incident sed dated 7/13, revealed the		Resident Protection policy. Far has implemented a tracking lot incidents to monitor proper documentation and reporting. The facility Social Worker or designee will interview 3 residue weekly to see if they have con and ensure follow-up is comp	dents

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			3	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NORTH DOW STREET CANNON FALLS, MN 55009	, 01 /	03/2014
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	surrounding the incinjury of unknown of bruises and skin teat allegation of injury, and/or maltreatment suspicious death of includes allegations and incidents of allest be documented in the Program of the EMF 3. Follow all immer procedures for manifestice act for situational including immediated Director. 5. The Executive Designees ensured for Social Services Designees ensured for Social Services and for Socia	ident is initiated. Any fall, r known origin, (including ars) medication errors, allegation of abuse, neglect it, self abuse/suicide attempt, a resident, elopement (this of resident to resident abuse aged financial exploitation) will he Risk Management R. diate reporting and notification dated reporting and elder ions of alleged abuse/neglect, a notification to the Executive irector, Director of Nursing ce Director and IDT ires that appropriate follow-up, westigation is he incident, and documents are ment interventions for safety	F2		and also monitor that the procedure is being followed. Administrator or designee will conduct weekly audits of at less staff to determine knowledge the facility's policy and proced for reporting and investigation resident incidents. Immediate education of staff will be completed if problems or inconsistencies are found. Results of audits will be communicated to the QA committee and action plans developed as needed. The facility will be substantial	of ure of	
	Procedure revised of following: page 5: # a. Upon receiving maltreatment, the E Director of Nursing/or designee will coor which will include co statements. b. All parties involve following-staff, residential page 5: # a. Upon receiving the page 5: # a. U	cipant Protection Policy and lated 12/12, directed staff the 2. Investigation: a complaint of alleged D (executive director), designee and Social services rdinate an investigation, impletion of witness red including two of the ent/client/participants or otentially involved, or			compliance with the standard indicated by 2/8/14.		

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUI A. BUILE	ILTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED		
	. •	245304	B. WING			ı	R / 03/2014	
	PROVIDER OR SUPPLIER CARE CENTER	,	<u> </u>	STREET ADDRESS, CITY, STATE, 300 NORTH DOW STREET CANNON FALLS, MN 5500		1 01/	103/2014	_
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	interviewed by ED, designee. Stateme Witness Interview F conducted with 2 stateme whenever possible/a f. Identify and impinterventions, i.e., in consultation. h. The investigation completed and revied Director/or designother officials in acculaw. A plan for full with input from approach completion of the will ensue to prevent as specified per k. The facility/service violations and will propotential abuse we progress.	DON, Social services or onts should be written on the orm. Interviews should be aff members present appropriate. Itement appropriate creased 1:1, psychological on and written findings are exwed with the Executive mated representative, and to ordance with state orther action is determined opriate personnel. In the investigative Data Sheet of turther occurrences policy. In every support of the investigation is in the ordance with state of the investigate all alleged event further while the investigation is in	F2	226				
; ;	a resident/client/partici resident/client/partici external business ve who: (continued on p Has knowledge of a resident/client/partici Has reasonable of resident/client/partici b. What is the proof facility/service? 1. After safeguarding	t suspected maltreatment of cipant? Any employee, pant, family/guardian, ndor or entity, or volunteer age 7) of suspected maltreatment of cipant. cause to believe that a pant has been maltreated. edure for reporting within the game that a gant (and all residents) as report the information to the						

		STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULT	TIPLE CONSTRUCTION	(V2) DATE CURVEY	
	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245304		B. WING_	į į	R 01/02/004 4	
NAME OF PROVIDER OR SUPPLIER				T	STREET ADDRESS, CITY, STATE, ZIP CODE	01/03/2014	
ANGELS CARE CENTER					300 NORTH DOW STREET		
ANGLES SAIL SENTEN			CANNON FALLS, MN 55009	٠			
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	F 226	Continued F	40				
	1 220	Tariminate and the page		F 22	26		
		officials in accordance	ed representative (and other ce with state law) must be		·		
		contacted immediate	ely by Supervisor or reporter				
		regarding all allegations of abuse/neglect.					
		Immediate reporting	may be reported via voice				
		mail, answering machine, or fax. Document date and time of notification.					
		and time of hotilication	OII.				
		Page 10: E. Definition	ons of Abuse and Neglect:				
		Abuse/Mistrea	atment is the willful infliction				
		of injury, unreasonab	ple confinement,		·		
		physical harm, pain,	r punishment with resulting				
		project nami, pam,	· · · ·				
		Page 11: #5. Verbal	Abuse:				
		The use of ora	al, written or gestured				
		derogatory tei	includes disparaging and				
		resident/client/particing	pants or their families, or				
		within their hearing					
		distance, rega	ardless of their age, ability to				
		comprehend, or disak	טווונץ.				
		Page 13: D. Psycholo	ogical/Emotional Abuse:	-			
	- 1	. #6. Use of rep	peated or malicious oral.				
		written or gestured lar	nguage toward a				
	,	vuinerable a Vuinerable adult which	dult or the treatment of a would be considered				
		by a reasona	ble person to be				
	(disparaging, derogato	ry, humiliating, harassing,				
		or	. 5,				
		threatening.					
	[During interview on 1/3	3/14, at 3:12 p.m.,				
	r	egistered nurse-B (RI	N-B) stated was aware of				
	F	R6 ' s family member '	's behavior, RN-B verified				
	[ne ramily member tall	ked loud, rude and nasty to stated the behavior had				
	-	ALIEL LESIGEHUS. MIN-B	stated the behavior had			1 1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1) DATE SURVEY COMPLETED	
		245304	B. WING		R		
NAME OF PROVIDER OR SUPPLIER			1 5. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE	01/03	3/2014	
ANGELS CARE CENTER				300 NORTH DOW STREET			
71110220				CANNON FALLS, MN 55009			
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F 226	F 226 Continued From page 13 occurred for a couple months. RN-B stated had reported the behavior to facility social services and administrator. During interview on 1/3/14, at 3:45 p.m., executive director stated F-A's verbal behaviors had occurred on-going since the middle of October 2013, at which time the family member had moved into the area. Executive director stated she expected staff to report all incidents of alleged abuse to her immediately. 483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION		F 22	3			
{F 318} SS=D			{F 318	F 318	2	48/14	
	resident, the facility with a limited range appropriate treatmer	nt and services to increase /or to prevent further		Residents R4, R20, R10, and R3 identified in this statement of deficiency have been reassesse services recommended by there including ROM, and updates we made to the care plan and care card.	d for apy, ere		
	by: Based on observation review, the facility fail motion (ROM) service R20, R10, R34) review Findings include: R4 lacked range of moccupational therapy R4 was observed on	ysical therapy and		Nursing staff was re-educated of 1/23/14 on following the reside care plan/care card for all cares including ROM and other service recommended by therapy and nursing and documentation of the services provided.	ent's i, es		

R 01/03/2014 NAME OF PROVIDER OR SUPPLIER ANGELS CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) [F 318] Continued From page 14 contractures at right elbow and wrist and also left wrist. R4 did not move upper extremities when requested. When packed if received range of	(X3) DATE SURVEY COMPLETED		(X2) MULTIPLE CONSTRUCTION A. BUILDING		TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				
NAME OF PROVIDER OR SUPPLIER ANGELS CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) [EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) [F 318] Continued From page 14 contractures at right elbow and wrist and also left wrist. R4 did not move upper extremities when requested. When payled if reached repairs of			A. BUILDING						
ANGELS CARE CENTER 300 NORTH DOW STREET CANNON FALLS, MN 55009				B. WING			245304		
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(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) [F 318] Continued From page 14 contractures at right elbow and wrist and also left wrist. R4 did not move upper extremities when required when page 14 wrist. R4 did not move upper extremities when required when page 14 wrist. R4 did not move upper extremities when required when page 14 wrist. R4 did not move upper extremities when recommendations from therapy for required when page 14 regions and when recommendations from therapy for required when page 15 writing the precise of the provided when recommendations from the provided when recommendations from the page 15 writing the precise of the provided when recommendations from the provided when recommendations from the provided when the precise of the provided when the precise of the provided when the provided wh				ì		ANGELS CARE CENTER			
FREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) FREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) The Nurse Managers have reviewed all residents on their units with recommendations from therapy for recommendations from therapy for			CANNON FALLS, MN 55009	\perp_{c}		7.11.02.20 07.11.2 02.11.2.1			
contractures at right elbow and wrist and also left wrist. R4 did not move upper extremities when	(X5) OMPLETION DATE	BE CO	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	FIX	PREF	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PRÉFIX	
motion or stretching of hands and arms, R4 nodded head no. The care plan provided 1/3/14 listed diagnoses that included multiple sclerosis, muscle spasm, and quadriplegia. R4's clinical record was reviewed. The nursing data collection tool (undated) provided 1/3/14 indicated R4 had diagnoses of multiple sclerosis and quadriplegia, and had limited range of motional to all extremities, had contractures in both upper and lower extremities. The collect tool indicated R4 participated in a restorative program twice a day. The quarterly minimum data set (MDS) dated 12/4/13 indicated R4 was totally dependent on staff for all activities of daily living and had upper and lower extremities impairment. The 6/15/13 quarterly MDS indicated R4 scored 6/15 (moderate mental impairment) on the BIMS (Brief Interview of Mental Status). The physical therapy evaluation form dated 7/30/12 noted R4 had limited active and passive range of motion. The physical therapy evaluation and certified plan of care dated 11/6/13 noted R4 had quadriplegia and long standing contractures with upper and lower extremities. Care plan dated 4/28/10 provided 1/3/14 indicated R4 had an intervention for a restorative nursing program and was to receive passive range of motion (PROM) to extremities twice a day. The Restorative Nursing Flow Sheet dated 7/30/12 indicated splints to be used twice daily on both hands. The restorative nursing linder also		rapy with in RAI de e on a e e list IDT needs c care	all residents on their units with recommendations from therap ROM or other services. Chang were made to the care plan an care card as needed. All residents not on skilled ther will be assessed quarterly and significant change for changes ROM, in conjunction with the Eprocess. The Nurse Managers have made and will maintain a list of all residents on their unit who are ROM or walking program or are receiving any other service recommended by therapy. The will be reviewed at the weekly Meeting. Resident's mobility needing. Resident's mobility needing. Resident's mobility needs at conferences. The list noted above will also be used at the Nursing Stations for documentation of services and			at elbow and wrist and also left ove upper extremities when asked if received range of g of hands and arms, R4 ded 1/3/14 listed diagnoses ale sclerosis, muscle spasm, was reviewed. The nursing (undated) provided 1/3/14 agnoses of multiple sclerosis and had limited range of amities, had contractures in the extremities. The collect tool pated in a restorative programm parterly minimum data set 3 indicated R4 was totally for all activities of daily living lower extremities impairment. The MDS indicated R4 scored and impairment) on the BIMS dental Status). The valuation form dated and limited active and passive the physical therapy evaluation care dated 11/6/13 noted R4 d long standing contractures are extremities. 8/10 provided 1/3/14 intervention for a restorative d was to receive passive are Nursing Flow Sheet dated wints to be used twice daily on	contractures at right wrist. R4 did not m requested. When a motion or stretching nodded head no. The care plan provi that included multip and quadriplegia. R4's clinical record data collection tool indicated R4 had diand quadriplegia, at motional to all extreboth upper and lower indicated R4 particip twice a day. The quadriplegia of motion of the foliation of the foliation of the foliation of the physical therape of motion. The physical therape of motion. The and certified plan of had quadriplegia an with upper and lower care plan dated 4/2 indicated R4 had an nursing program and range of motion (PF) day. The Restorative 7/30/12 indicated sp		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
•		245304	B. WING		R 01/03/2014		
NAME OF PROVIDER OR SUPPLIER ANGELS CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREVIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE			
	instructions for range extremities 5-10 reperextremities 10 reperextremities 11 reperextremities 10 reperextremities 11 reperextremities 11 reperextremities 10 reperextremities 11 reperextremities 10 reperextremities 11 reperextremities 10 repere	labeled with R4's name with per of motion to lower petitions daily and left upper litions daily signed by y. Deduction of the daily signed by the daily signe	{F 31	and/or nurses are response monitoring compliance. A new Therapy to Nursing Communication form has developed and implement improve communication or therapy recommended set. Nurse Managers/designed weekly audits on at least 3 residents on their unit who ROM or walking programs receiving any other service recommended by therapy ensure appropriateness of and compliance with policiprocedures. Results of the audits will be reviewed by the QA Communication plans developed as Audit frequency will be recommendations from the Committee.	been ted to elated to rvices. will do o are on or are to services y and e nittee and needed. duced		
	The quarterly MDS require extensive as hygiene and to requitransfers and to hav	10/22/13 showed R20 to sistance with dressing and re total assistance with e functional limitations of all e MDS identified R20's BIMS					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTI NG	ON		TE SURVEY MPLETED
	•	245304	B. WING			1	R
NAME OF	PROVIDER OR SUPPLIER		1 5. 11.110	OTDEET ADDDER	O OITY OTATE ZID OODE	01	/03/2014
	CARE CENTER			300 NORTH DOV			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH C	VIDER'S PLAN OF CORRECTI CORRECTIVE ACTION SHOUL EFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
	at 15/15 or no cognidated 7/23/13 indicated 7/23/13 indicated recoordination, poor by work with resident to level. The physical therapy 1/31/13 indicated a motion program had restorative nursing poccupation therapy passive range of motion to left upper daily and to bilateral daily. When requested, no provision of range of provided. Nursing a interviewed on 1/3/1 he was responsible for R20, but had not have time to do so. R10 lacked range of recommended by the On 1/3/14 at 2:15 p.1 range of motion. R1 to straighten the 3rd an related to contracture.	attive impairment. The CAA ated R20 had physical ange of motion, poor valance and that staff would or maintain current functioning by discharge summary dated lower extremity range of discharge form signed by directed upper extremity botion 10 repetitions daily. Interventions dated 2/28/13 of one for passive range of extremity 10 repetitions (reps) lower extremities 5-10 reps Industrial documentation related to find for R20 was ssistant (NA)-A was 4 at 11:00 a.m. NA-A stated for providing range of motion done so because he did not motion services as a physical therapist In R10 stated did not get 0 was observed and asked R10 was unable to and 4th fingers of the left hand	{F 31	be respond complianc The facility substantia	DN and/or designee sible for maintaininge. y alleges that it will all compliance with the indicated by 2/8/14	g be in he	
	diagnoses of paraple	egia, muscle weakness, pain					

1		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION ING	(X3) DA	TE SURVEY MPLETED	
			245304	B. WING	FED 5 2013	01	R / 03/2014	
	ANGELS	PROVIDER OR SUPPLIER CARE CENTER	·		STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009	1 01	703/2014	-
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE	-
	i a i i a i i i i i i i i i i i i i i i	tool dated 10/23/13 functional impairment lower extremities. impairments of upper limitation to bilateral contractures. The correceived restorative The quarterly MDS of required total assistate extensive assistance functional limitations BIMS score of 14/15. The CAA dated 2/11/ limitations, weakness poor balance. The restaff would work with current function level The physical therapy indicated weakness, ankle and R10 would motion program. The restorative nursing signed by physical therapy extremities twice a day when requested, no provision of range of provided. Nursing as interviewed on 1/3/14 are was responsible for R10, but had not cave time to do so. The unit manager registrements of the unit manager registrements of the unit manager registrements.	b. Ing quarterly data collection indicated no upper extremity int and impairment of both The collection tool stated no increment of both The collection tool stated no increment of both The collection tool stated no increment of both Increment of motion of motion of motion increment of motion increment increment of motion in	{F 31	8}			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION DING		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009		/03/2014
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		OULD BE	(X5) COMPLETION DATE
	indicated orders we therapy for range of of motion was discuteam (IDT) meeting minutes being kept. was responsible to related to range of rassistants complete computer information done. The director of nurs 1/3/14 at 10:50 a.m. provided to R4, R20 notes were maintain documented discuss programs. She stat nursing assistants we changes with the ne stated that since no one had noticed lack added the nurse madocumenting month participation and good During an interview administrator indicat policy/procedure relations.	for R4, R20, R10. RN-A re developed by physical motion. RN-A stated range assed in interdepartmental s, but was not sure about RN-A stated that nursing complete the MDS information notion and that nursing the point of care (POC) on when range of motion was sing (DON) was interviewed on about range of motion (PR10. DON stated no IDT and so there was no sion of restorative nursing ed that POC documented by as not completed because of w facility ownership. DON audits had been done, no a conference of documentation. DON angers were responsible for angers were responsible for all the sister facility would stated to resident range of that the sister facility would	{F 31	18}		
.	recommended by oc	range of motion services as cupational therapy. the facility Admission Record				

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DAT	E SURVEY MPLETED
		245304	B. WING				R 03/2014
	PROVIDER OR SUPPLIER CARE CENTER			300	REET ADDRESS, CITY, STATE, ZIP CODE NORTH DOW STREET NNON FALLS, MN 55009	1 017	30/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
{F 318}	diagnosis of Alzheir agitans.	on form, identified R34 had ner's disease and paralysis	{F 3⁻	18}			
	Minimum Data Set have short and long severely impaired d dependence on one daily living, received program, no range assistance, and had	d R34 on the quarterly (MDS) dated 10/10/13, to term memory problem, ecision making, total to two staff for activities of no restorative nursing of motion, no splints or brace I functional limitation in range n upper extremity on one					
	motion/balance ass revealed R34 had fumotion on both side non-ambulatory, tra and two staff, unabl attempt to self-trans	the facility quarterly range of essment dated 10/8/13, unctional limitation in range of s of upper extremity, was ensferred with mechanical lift to to follow commands and fer or move extremities, and oth upper extremities.					
	assistant-E (NA-E) s	1/3/14, at 10:39 a.m., nursing stated hospice staff performed roises to R34's hands when					
	R34 was positioned room with television response to question have bilateral hands hands. During internassistant (NA)-G stamotion exercises to NA-G stated staff us	on 1/3/14, at 10:50 a.m., in geriatric chair in resident on. R34 made no verbal ns. R34 was observed to contracted with no splints on view at that time, nursing ted she performed range of R34's hands that morning. e to document range of mpleted but the new					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245304	B. WING				R
NAME OF	PROVIDER OR SUPPLIER	243004	1		STREET ADDRESS, CITY, STATE, ZIP CODE	01/	03/2014
	CARE CENTER			.3	800 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 318}		ge 20 place on 12/20/13, did not ation of range of motion	{F 3∙	18}			
*	NA-G pushed R34 i dining room. Obser R34's hands were c hands. During inter verified R34's hands	s on 1/3/14, at 11:30 a.m., in the geriatric chair to Oasis vations at that time revealed ontracted with no splints on view at that time, NA-G is were contracted and stated in the hand splints applied that					
	Recommendations trevealed instructions gentle range of moti	Occupational Therapy to nursing staff dated 8/16/13, is to wash bilateral hands, on, fit splints in right and left urs on in the morning and two on.					
	1/24/13, identified at more independence nursing program, an other programs; #16-dated 1/22/13, i	facility CAA worksheet dated t #2-resident has potential for with cueing, restorative d/or task segmentation or dentified delirium limits mitation in range of motion.					
	of nursing stated the documentation of ra- lacked interdisciplina motion, lacked range	1/3/14, at 10:50 a.m., director facility lacked any nge of motion performed, ary notes related to range of the of motion documentation by a point of care, due to a new		-			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY MPLETED	
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	PROVIDER OR SUPPLIER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 300 NORTH DOW STREET CANNON FALLS, MN 55009		/03/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE	
{F 318}	discussion of range nursing programs. If facility had not compif residents received nursing verified nurs responsible for docurelated to range of nestorative nursing puring interview on executive director vecomputer program vacked documentation exercises.	and no documentation of of motion and restorative Director of nursing verified the pleted any audits to determine I range of motion. Director of se managers were umenting a monthly note notion and participation in program. 1/3/14, at 11:50 a.m., erified the facility new was effective 12/20/13, and on for range of motion	{F 31	18}			
	R34 was discharged on 8/15/13, with goa instructed nursing st exercises and splints procedure was for C occupational therapy nursing staff form winursing to continue r COTA stated she gardated 8/16/13, to the stated when resident occupational therapy occupational therapy followed by nursing. Document review of report dated 8/26/13, restorative nursing prodecreased mobility/crange of motion and	f, she was not aware if recommendations were facility resident care plan identified focus of rogram to decrease risk of contractures; goal to maintain					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		LE CONSTRUCTION	(X3) DA	(X3) DATE SURVEY COMPLETED	
	•	245304	B. WING	i			R	
	PROVIDER OR SUPPLIER			S 3	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NORTH DOW STREET CANNON FALLS, MN 55009	<u>I 01</u>	/03/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
{F 318}	staff to wash bilatera motion to both hand hands, allow finger it to prevent tightness day for two hours. During interview on executive director vermonthly clinical man range of motion as vertical completed for R34, it new computer systems.	al hands, gentle range of s, fit splints in right and left room between straps and skin, staff to apply two times a 1/3/14, at 1:45 p.m., erified the facility lacked ager summary related to written in facility plan of e director verified the facility ange of motion exercises before or after the 12/20/13 m.	{F 3	18}				
{F 323} SS=D	483.25(h) FREE OF HAZARDS/SUPERV The facility must ensenvironment remains as is possible; and e	ACCIDENT ISION/DEVICES	{F 32		Resident R67 skin was assessed nursing re: the identified redde area on the wrist. It is reasona to conclude that the watch was cause of the reddened area, the watch was removed and family	ened ble s the e	2/8/14	
	by: Surveyor: Lageson, Based on observation review, the facility fail thoroughly investigate in a timely manner fo reviewed and the faci residents in the dining coffee pot and hangir located to ensure resi	his REQUIREMENT is not met as evidenced is surveyor: Lageson, Jennifer ased on observation, interview, and document view, the facility failed to consistently monitor, oroughly investigate and report a left wrist injury a timely manner for 1 of 3 residents (R67) viewed and the facility failed to supervise sidents in the dining room where a hot metal offee pot and hanging electrical cords were cated to ensure residents were safe from burns. his had the potential to affect 34 or 58 residents		- -	notified. Plan of care was updato include monitoring for skin conditions. The IDT reviewed recent reside incidents to determine complia with facility policy and procedu	nt nt nce		

STATEME AND PLAI	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245304	B. WING	- 120 7 69/4) .	R
NAME O	F PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	01/03/2014
ANGEL	S CARE CENTER			300 NORTH DOW STREET CANNON FALLS, MN 55009	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CO IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
{F 323	Continued From page who had access to the Findings include: R6 which included reddend However, the incider investigated, reporte per facility policy and On 1/3/2014 at 10:30 observed. The resident marks almost all around was slightly swollen. complain of pain. Resurveyor how it happed A quarterly Minimum was reviewed for R67 with moderate cognities extensive assist to to daily living. An Incident report dain reviewed. It noted that morning, a licens noticed R67 had a remeasuring 12 cm x 2 smaller reddened are Area markings match Resident was aware the watch. The immediate removed on 12/27/20 nurse aide had discovered with the country of the reddend and LPN- C further documents.	ge 23 he coffee pot. 7 had injury to the left wrist ened swollen areas. In thad not been thoroughly do to the executive director domination of monitored consistently. 9 a.m., R67's left wrist was ent had deep reddened und the left wrist. The wrist The resident did not 67 Was unable to tell the ened or what caused it. Data Set dated 11/21/2013 7. It identified the resident ive impairment and required tal assist for activities of	{F 323	Further follow-up and staff re-	ded. veekly e for re- nere may A s ess rts
	memory. R67 owned t reported as the cause	the property and it was not	i	12 and on the correct way to	

PROVIDER OR SUPPLIER ANGELS CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES		IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
MAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009			245304		FEB 1 2019	R
(F 323) Continued From page 24 Nursing progress notes and interdisciplinary notes dated 12/25/2013 through 12/30/2013 were reviewed. No notes were evident for the date of 12/27/2013 went he nurse aide. A progress note dated 12/28/2013 at 22:11 stated the nurse noticed a rash around neck on left side and left wrist area. There was no further documentation evident regarding the incident that was identified on 12/30/2013. No thorough investigation, or follow up or monitoring. R67's care plan with completion date of 12/9/2013—did not identify issue with watch removal related to swelling and redness of wrist and hand. The 24 hour board dated 12/25/2013 through 12/30/2013 was reviewed for the wing R67 resided on. The monitoring of the resident's left wrist injury was not documented to be checked and followed up on was not evident until 12/30/2013 when the incident report of nursing (DON) was interviewed regarding accident/incident reporting and the procedure. Incidents are reported to administrator, then looked into to see if reportable issue. If warrants more input will contact Social Service and Director of Nursing. All incidents and falls are brought to morning meeting every day and then the interdisciplinary team (IDT) would review and come up with interventions. The DON or nurse manager would make a note in the computer as follow up. The incidents were put on the 24 hour stage of the stage of the stage of the procedure was created for when facility runs out of coffee in its Nescafe Coffee Machine. Policy was reviewed with all dietary staff.	ANGELS	S CARE CENTER			300 NORTH DOW STREET	01/03/2014
Nursing progress notes and interdisciplinary notes dated 12/2/52/2013 through 12/30/2013 were reviewed. No notes were evident for the date of 12/27/2013 when the incident was found by the nurse aide. A progress note dated 12/28/2013 at 22:11 stated the nurse noticed a rash around neck on left side and left wrist area. There was no further documentation evident regarding the incident that was identified on 12/30/2013. No thorough investigation, or follow up or monitoring. R67's care plan with completion date of 12/9/2013—did not identify issue with watch removal related to swelling and reddness of wrist and hand. The 24 hour board dated 12/25/2013 through 12/30/2013 was reviewed for the wing R67 resided on. The monitoring of the resident's left wrist injury was not documented to be checked and followed up on was not evident until 12/30/2013 when the incident report was made out (2-3 days after the incident). On 1/2/2014 at 3:00 p.m. the director of nursing (DON) was interviewed regarding accident/incident reportated to administrator, then looked into to see if reportable issue. If warrants more input will contact Social Service and Director of Nursing. All incidents and falls are brought to morning meeting every day and then the interdisciplinary team (DT) would review and come up with interventions. The DON or nurse manager would make a note in the computer as follow up. The incidents were put on the 24 hour	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COMPLETION
		Nursing progress no notes dated 12/25/2 reviewed. No notes 12/27/2013 when the nurse aide. A progre 22:11 stated the nurse neck on left side and no further document incident that was ide thorough investigation. R67's care plan with 12/9/2013did not ideremoval related to swand hand. The 24 hour board do 12/30/2013 was revieresided on. The more wrist injury was not do and followed up on word 12/30/2013 when the out (2-3 days after the control of Nursing. A corought to morning manager would make ollow up. The incidents are reported to the control of Nursing. A corought to morning manager would make ollow up. The incidents are reported to the control of Nursing. A corought to morning manager would make ollow up. The incidents are reported to the control of Nursing. A corought to morning manager would make ollow up. The incidents are reported to the control of Nursing. A corought to morning manager would make ollow up. The incidents are reported to the control of Nursing. A corought to morning manager would make ollow up. The incidents are reported to the control of Nursing. A corought to morning manager would make ollow up. The incidents are reported to the control of Nursing. A corought to morning manager would make ollow up. The incidents are reported to the control of Nursing. A corought to morning manager would make ollow up. The incidents are reported to the corought to morning manager would make ollow up. The incidents are reported to the corought to morning manager would make ollow up.	otes and interdisciplinary 013 through 12/30/2013 were were evident for the date of eincident was found by the ess note dated 12/28/2013 at se noticed a rash around dieft wrist area. There was ation evident regarding the ntified on 12/30/2013. No on, or follow up or monitoring. completion date of lentify issue with watch welling and reddness of wrist exed 12/25/2013 through exwed for the wing R67 nitoring of the resident's left ocumented to be checked ras not evident until incident report was made e incident). o.m. the director of nursing end regarding orting and the procedure. If warrants ext Social Service and All incidents and falls are eeting every day and then eam (IDT) would review and intions. The DON or nurse a note in the computer as ints were put on the 24 hour	{F 323	The Director of Nursing, Administrator and Social Work will monitor compliance with t facility's policy and procedures incidents. The IDT team will re each incident report for completion. Metal Coffee pot, with electric attached, was removed immediately from dining room and placed in the kitchen. Met coffee pot was labeled "not for resident use – kitchen use only R1 did not receive any burns or injury from metal coffee pot. Policy and Procedure was creat for when facility runs out of cod in its Nescafe Coffee Machine. Policy was reviewed with all die staff. Education on environmental hazards was completed with all	he for view cord area al . ". ted ffee etary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. (X2) MULTI	PLE CONSTRUCTION		E SURVEY MPLETED
	245304	B. WING		1	R /03/2014
NAME OF PROVIDER OR SUPP		1	STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009	1 01/	03/2014
PRÉFIX (EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICENCY)	D BE	(X5) COMPLETION DATE
interviewed reg wrist. She said 12/30/2013 (Moreport at that tir 12/27/2013 by a by the nurse on previewed the conurse and indice and identified a verified there we incident or investigation of the conurse and indice and identified a verified there we incident or investigation of the conurse and indice and identified a verified there we incident or investigation of the conurse and incident or investigation of the conurse and incident or investigation of the conurse and incident and she reported in the completed on the conurse and information of the conurse and indicessing the conurse and in	arding the incident of R67's left she became aware of it on onday) and made out the incident ne. The incident was found on a nurse aide and a note was made that day (a Friday). LPN-C locumentation of the previous ated it was done on 12/28/2013 rash of the left wrist. LPN-C as no further documentation of the stigation. 11:05 a.m., DON was interviewed ting of the incident that occurred was not taken care of until e indicated it has always been the mmediately to the executive d always was being done. 11:30 a.m., the DON indicated the discovered by a nurse on the 28th report according to the facility her nurse noticed it on Monday d it. It was reported to DON but ne incident report was not	{F 323	Random Environmental auditable performed by the Mainten Director or designee two time month to monitor for complia Results of audits will be reporthe QA committee and action developed as needed. The facility will be substantial compliance with the standard indicated by 2/8/14.	ance es a nce. ted to plans	
report, she verifi nurse was being On 1/3/2014 at 2 should be monit	213. The nurse didn't do the ed she wasn't notified and the counseled regarding that. 2:30 p.m., the DON indicated they bring the skin incident. It should be board which then they are to				

STATEMENT OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245304	B. WING		1	R	
NAME OF BR	OVIDER OR SUPPLIER	245304	B. WING		01/	/03/2014	
	ARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE	(X5) COMPLETION DATE	
dout of Si Richard Si	ntil the nurse mana kay. urveyor: Sorensen I was sitting at a tainking coffee at 3:0 ine was able to get the direction of a reputer in the dining hot metal electric of a reserved plugged in ning room. The posted over the count as wrapped around as wrapped around do loosely under the electrical outlet to estaff in dining roof eect vision from the the counter in the 3:05 p.m. the dieta ffee pot would confee machine was we dry coffee to make the conds due to it bei n. the administrator to fore this mone et it was to hot to to	es. They are to keep track agers decide everything was a gers decide everything room on 1/2/14. R1 stated coffee herself and pointed us metal coffee pot on the room. On 1/2/14 at 3:00 p.m. If 00 cup coffee pot was to the electrical outlet in the our spigot of the coffee pot everythe edge. The electrical cord of the front of the counter to on the back wall. There was on and staff did not have exitchen to see the coffee pot edining room. The ary aid (DA)-C stated the ne out anytime the Nescafe empty and the facility did not ake more. DA-C was unable inst the pot for a count of 5 ng hot to the touch. At 3:08 or stated the facility had run rining and then they use the resident and visitor use. Uched the coffee pot and said buch for long. After touching	{F 32				
froi to t	m resident access use safely. 3:20 p.m. DA-C ch	ministrator removed the pot as it was to hot for residents necked the temperature of e kitchen. The coffee in the					

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245304	B. WING			R / 03/2014	
	PROVIDER OR SUPPLIER S CARE CENTER	·		STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009	1 01.	100/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI ((EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
{F 323}	100 cup electrical of DA-A stated the factory often, but that it the metal coffee point At 3:20 pm on 1/2/1 manager (CDM) was she had suggested the counter and that usually used when the She stated the coffee placed in an area with the stated the coffee placed in an area with the company of the stated the coffee placed in an area with the coffee placed in an area with the company of the counter and the coffee placed in an area with the company of the c	offee pot was 160 degrees. ility did not run out of coffee t had happened before and was used at that time. 4 the certified dietary s interviewed. CDM stated the coffee pot be placed on this 100 cup coffee pot was he facility ran out of coffee. he pot should have been here residents did not have	{F 32	3}			
	unaware of any burn Review of incident re December 2013 did from coffee. At 3:25 p.m. on 1/2/(DON) indicated the non-specialty unit in have access to the of unable to get to the 4:00 p.m. DON provicould independently and at 5:15 p.m. star	esons. CDM stated she was as from the coffee. eports from June through not reveal any resident burns 14, the director of nursing re were 42 residents in the the nursing home that could coffee unless they were dining room themselves. At ided a list of 34 residents that have access to the coffee ted none of these residents intia. DON indicated R1 was	·				
{F 371} SS=F	on that list. 483.35(i) FOOD PROSTORE/PREPARE/S The facility must - (1) Procure food from considered satisfactor authorities; and	DCURE, SERVE - SANITARY In sources approved or bry by Federal, State or local stribute and serve food	{F 37	()			
1	•						

			_,		VID IVO	<u>. 00</u> 00-009	,,
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED	
	·	245304	B. WING	B. WING			
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	01/	/03/2014	
	CARE CENTER			300 NORTH DOW STREET CANNON FALLS, MN 55009			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	!
{F 371}	Continued From pag	ge 28	{F 371}	F 371		2/8/14	?
	·	·		The facility will store, prepare distribute and serve food und sanitary conditions.			
	by: Based on observation review, the facility farenvironment to prevent illness which include equipment cleaning, storage of dishes for the potential to affect facility that had been distributed from the findings include: Soiled gloves used to Food preparation/ser the noon meal on 1/2 (DA)-A was observed then held a clip board leg; mixed juice; tough glasses as she place opened the refrigerate poured the milk into eset out; again opened ouched items in the change her gloves. If hickener can, touch the spoon into the thickener to the milk. Wiped her hands on he changed the gloves desired.			Staff was educated on infection control practices, the use of gloves, and the sanitary handle of equipment. The surface of the Dishwasher been cleaned. The task of the cleaning the dishwasher was added to the cleaning checklist each shift. Both fans were removed from service. All staff have been educated on the policy and procedure for testing chemical balance for the the low temperature dishwashing machinand properly documenting the information. A monitoring system has been set up for assuring proper chemical levels are used and all cooks in-serviced.	r has et for the the		
t		t would come in contact with					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	· •	245304	B. WING _	Mil Dept of Health	i i	R 03/2014
	PROVIDER OR SUPPLIER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009	1 011	00/2014
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	contaminated surface During an interview stated that she had could not remember training related to the hire orientation but the kitchens in the past. Dishwasher and sare The dishwasher and sare The dishwasher top was noted to have low the initial kitchen towas noted to have low the initial kitchen towas noted to have low the dishwasher top was noted to have low the dishwasher that debris indicated the area has stated that each time lifted some debris cand remained on the dishwasher and that time the wall and one for the wall and one for the wall and one for blowing directly on the dishes were removed stated the fans were dishes. The dishwasher was	on 1/2/14 at 11:36 a.m. DA-A not changed her gloves and is she had received any e use of gloves during new hat she had worked in hitation of dishes: Docess was observed during ir on 1/2/14 at 10:00 a.m. above the clean dishes door pose debris that would move opened to remove the dishes. All the administrator and ager (CDM) had also on top of the dishwasher and ad not been cleaned. CDM are the dishwasher door was ame out of the dishwasher e surface on top of the she did not know the last surface had been cleaned. Or and CDM stated that the of the clean dishes. All during a tour with the ewere 2 fans (one attached the sanitized dishes after the diffrom the dishwasher. CDM used to help dry the cleaned as low temperature chemical and machine provided by ECO	{F 37	Staff have been adjusted on	s as owl vas dit of l and rface and e	
		log for December 18		·		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULT A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245304	B. WING _		f .	R 01/03/2014	
	PROVIDER OR SUPPLIER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009	<u> 01/</u>	03/2014	
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	numbers document from 40, 45, 89, 75 guidelines noted on tests range of 10, 50 stated the facility do with the test strip raid documented at 50 or Lab had last been in dishwasher in Nove sanitation was at the that if the sanitation to let her know, but a problem. CDM state and test the sanitation numbers were ok. Food preparation equation to let her know, but a problem. CDM state and test the sanitation numbers were ok. Food preparation equation are with CDM, observed to have clean orange substance inside to cover two lates as part of the food p that the bowl did not and placed the bowl dishwasher again. On 1/2/14 at 12:00 m CDM observed the bowl dishwasher and Clean or the food p that the bowl dishwasher and Clean of the bowl of the glued area in the glued area in the	Is reviewed with the DM. The chemical sanitation ed on the facility log ranged and 50 or 100 while the the chemical test strips noted 0, 100, and 200. CDM cumentation did not agree nge and should be at 100. CDM stated that ECO of the facility to test the mber 2013 to verify the ecorrect level. CDM stated was less than 40, staff were she had not been notified of a ed she would look at the logs on levels again, so felt the liquipment: 1/14, while touring the clean a clear plastic bowl was ear tape on the outside and economic looked like glue) on the large cracks in the bowl. It is a clean dish and was used uree processor. CDM stated have a cleanable surface	{F 371	documentation of chemical testing will be completed by dietary director or designee for one month and twice a w for a month. Results of the audits will be reduced based compliance and recommendations from the committee. The Dietary Director is responsible for on-going compliance. The facility will be substantial compliance with the standard indicated by 2/8/14.	daily eek on QA		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
	·	245304	B. WING _		R 01/03/2014
	PROVIDER OR SUPPLIER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009	
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{F 371}	prepared: The pipes contained covered with dust particular directly over the coordinate of the coordin	ervice until replaced. over the stove where food was divithin the hood were articles. These pipes ran ok burners and the open paring resident food. The lity had contracted another lovember to clean the range not been done since. CDM difall into uncovered pots process. CDM stated dietary ne walls and range hood	{F 371	1}	

IVIInneso	<u>ita Department of He</u>	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00758	B. WING		R 01/03/2014	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
4110510	OADE OFNITED	300 NORT	H DOW STF	REET		
ANGELS CARE CENTER CANNON		FALLS, MN	55009			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
{2 000}	Initial Comments		{2 000}			
	*****ATTE	NTION*****				
	NH LICENSING CORRECTION ORDER					
	144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been compliance with all rule provided at the tag ale number indicated below. In the items will be considered be the items will be considered be been been been been been been been				
	that may result from orders provided tha the Department witl	hearing on any assessments non-compliance with these tawritten request is made to nin 15 days of receipt of a nt for non-compliance.				
	01/03/14. During th determined that the # 0895, 1015, 1980 corrected. This unc effect and will be re	visit was completed on		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota state statutes/rules for Homes.	oftware. to	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
711012711	or connection	BENTH TO ATTOMBET.	A. BUILDING:			
		00758	B. WING		R 01/03/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ANGELS	CARE CENTER		TH DOW STF FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{2 000}	Continued From page 1		{2 000}			
	possible penalty as			The assigned tag number appears far left column entitled "ID Prefix The state statute/rule out of complisted in the "Summary Statement Deficiencies" column and replaces Comply" portion of the correction of This column also includes the find which are in violation of the state is after the statement, "This Rule is a sevidence by." Following the surfindings are the Suggested Metho Correction and Time period for Correction and Time period for Correction and Time period for Correction." THIS APPLIES FEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT T SUBMIT A PLAN OF CORRECTION STATUTES/RULES.	Tag." liance is of sthe "To order. ings statute not met veyors d of orrection. DING OF TO THIS O DN FOR	
{2 895}	MN Rule 4658.0525 Motion	5 Subp. 2.B Rehab - Range of	{2 895}			
	that is directed towa through positioning implemented and m comprehensive res of nursing services development of a n provides that: B. a resident wit	motion. A supportive program and prevention of deformities and range of motion must be naintained. Based on the ident assessment, the director must coordinate the ursing care plan which				
		e treatment and services to				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00758	B. WING		01/0	R 03/2014
	NAME OF PROVIDER OR SUPPLIER STREET AS 300 NOR ANGELS CARE CENTER CANNON					
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{2 895}	increase range of m decrease in range of This MN Requirements by:	notion and to prevent further	{2 895}			
	original licensing or remain in effect. Pe Based on observati review, the facility fa motion (ROM) serv	der issued on 11/08/13, will malty assessment issued. on, interview and record ailed to provide range of ices for 4 of 4 residents (R4, iewed for ROM services.				
	Findings include: R4 lacked range of recommended by p occupational therap	hysical therapy and				
	in a wheelchair in ro contractures at righ wrist. R4 did not m requested. When a	n 1/3/14 at 11:50 a.m. sitting from. R4 was noted to have t elbow and wrist and also left ove upper extremities when asked if received range of g of hands and arms, R4				
	·	ded 1/3/14 listed diagnoses le sclerosis, muscle spasm,				
	data collection tool indicated R4 had di and quadriplegia, a motional to all extre both upper and low	was reviewed. The nursing (undated) provided 1/3/14 agnoses of multiple sclerosis and had limited range of emities, had contractures in er extremities. The collect tool pated in a restorative program				

Minnesota Department of Health

STATE FORM 6899 ETLH12 If continuation sheet 3 of 29

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY LETED
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	00758		B. WING		01/0	≀ 3/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ANGELS	CARE CENTER		TH DOW STF FALLS, MN			
(VA) ID	CLIMMA DV CTA	TEMENT OF DEFICIENCIES	-	PROVIDER'S PLAN OF CORRECTION)NI	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETE DATE
{2 895}	Continued From pa	ge 3	{2 895}			
(2 090)	twice a day. The question (MDS) dated 12/4/1 dependent on staff and had upper and The 6/15/13 quarte 6/15 (moderate me (Brief Interview of Note 15 moderate May 12 moderate plan dated 4/2 indicated R4 had an ursing program arrange of motion (Pf day. The Restoration 7/30/12 indicated spoth hands. The rehad a picture guide instructions for range extremities 5-10 rependent the structure of the provision of range of Nursing assistant Note 11:00 a.m. NA-Approviding range of range of the structure of the struct	uarterly minimum data set 3 indicated R4 was totally for all activities of daily living lower extremities impairment. rly MDS indicated R4 scored ntal impairment) on the BIMS Mental Status). by evaluation form dated ad limited active and passive he physical therapy evaluation for care dated 11/6/13 noted R4 nd long standing contractures er extremities. 28/10 provided 1/3/14 in intervention for a restorative and was to receive passive ROM) to extremities twice a ve Nursing Flow Sheet dated colints to be used twice daily on estorative nursing binder also labeled with R4's name with ge of motion to lower petitions daily and left upper titions daily signed by	(2 090)			
		of motion services as ne physical therapy and by.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					F	?
		00758	B. WING		01/0	3/2014
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ANGELS	CARE CENTER		'H DOW STF FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
{2 895}	Continued From pa	ge 4	{2 895}			
	On 1/3/13 at 11:15 in a wheelchair. W	a.m. R20 was observed sitting hen asked R10 was unable to hands. R20 stated that staff				
	diagnoses of multip soft tissues of limbs	ded 1/3/14 identified ble sclerosis, dementia, pain in s, muscle weakness, abnormal f joint, lack of coordination.				
	The nursing quarterly data collection form dated 10/17/13 indicated upper and lower functional impairment. The collection form noted R20 had multiple sclerosis and limitation in all extremities, contractures to bilateral ankles, left shoulder and left fingers and was receiving range of motion. The quarterly MDS 10/22/13 showed R20 to require extensive assistance with dressing and hygiene and to require total assistance with transfers and to have functional limitations of all four extremities. The MDS identified R20's BIMS at 15/15 or no cognitive impairment. The CAA dated 7/23/13 indicated R20 had physical limitations, limited range of motion, poor coordination, poor balance and that staff would work with resident to maintain current functioning level.					
	1/31/13 indicated a motion program had restorative nursing occupation therapy	loy discharge summary dated lower extremity range of developed. The program form signed by directed upper extremity otion 10 repetitions daily.				
	that directed assist motion to left upper	nterventions dated 2/28/13 of one for passive range of extremity 10 repetitions (reps) I lower extremities 5-10 reps				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00758	B. WING		01/0	R 03/2014
	PROVIDER OR SUPPLIER	300 NORT	DRESS, CITY, S TH DOW STF FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{2 895}	When requested, n provision of range of provided. Nursing a interviewed on 1/3/1 he was responsible for R20, but had no have time to do so. R10 lacked range of recommended by the Contraction of the Straighten hands straighten the 3rd a related to contracture. The care plan providiagnoses of parapin soft tissues of lim	o documentation related to of motion for R20 was assistant (NA)-A was 14 at 11:00 a.m. NA-A stated for providing range of motion t done so because he did not of motion services as the physical therapist how was observed and asked at R10 was unable to not at mid joint. ded 1/3/14 indicated R10 had legia, muscle weakness, pain ab.	{2 895}			
	tool dated 10/23/13 functional impairmed lower extremities. impairments of upp limitation to bilatera contractures. The creceived restorative The quarterly MDS required total assist extensive assistant functional limitation BIMS score of 14/1 The CAA dated 2/1 limitations, weakned poor balance. The staff would work wit current function leverage impairment in the staff would work wit current function leverage impairment staff would work with current function leverage impairment in the staff would work with t	ing quarterly data collection indicated no upper extremity ent and impairment of both. The collection tool stated no er extremities but has I lower extremities, no ollection tool indicated R10 enursing for range of motion. dated 10/24/13 indicated R10 each with transfer and ewith dressing and hygiene; so foth lower extremities; fon mental impairment). 1/13 indicated physical ess, limited range of motion, rational for care plan stated the resident to maintain/improve el of ADLs.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		-	_
		00758	B. WING		01/0	^ਜ)3/2014
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ANGELS	CARE CENTER		H DOW STF			
ANGLE	OANE OENTEN	CANNON	FALLS, MN	55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{2 895}	ankle and R10 wou motion program. The restorative nursigned by physical range of motion daireps each. The cardated 8/27/12 of accentremities twice a When requested, no provision of range of provided. Nursing a interviewed on 1/3/he was responsible for R10, but had no have time to do so. The unit manager ranterviewed on 1/3/the range of motion indicated orders we therapy for range of motion was discuteam (IDT) meeting minutes being kept was responsible to related to range of assistants complete computer informatic done. The director of nursi 1/3/14 at 10:50 a.m. provided to R4, R20	s, limited range of motion of ld benefit from range of sing program flow sheet therapy 8/6/13 directed active ly to both lower extremities 10 e plan had an intervention tive range of motion to lower day. o documentation related to of motion for R10 was	{2 895}			
	programs. She stanursing assistants or changes with the no stated that since no	ssion of restorative nursing ted that POC documented by was not completed because of ew facility ownership. DON a audits had been done, no ek of documentation. DON				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE SURVEY COMPLETED	
		00758	B. WING			R 03/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE			
ANGELS	CARE CENTER		TH DOW STR I FALLS, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
{2 895}	added the nurse madocumenting month participation and go During an interview administrator indical policy/procedure remotion, but thought have one. R34 did not receive recommended by o Document review on Resident Information diagnosis of Alzheir agitans. The facility identified Minimum Data Set have short and long severely impaired of dependence on one daily living, received program, no range assistance, and had of motion impaired side. Document review of motion/balance assisted R34 had firmotion on both side non-ambulatory, trained and two staff, unabla attempt to self-transhad impairment in buring interview on During interview on the side non-ambulatory.	anagers were responsible for ally related to range of motion bals. on 1/3/14 at 4:00 p.m. the atted she was unable to find a lated to resident range of a that the sister facility would be range of motion services as a ccupational therapy. If the facility Admission Record on form, identified R34 had mer's disease and paralysis and R34 on the quarterly (MDS) dated 10/10/13, to get the term of the two staff for activities of the dinorestorative nursing of motion, no splints or brace and functional limitation in range in upper extremity on one for the facility quarterly range of the facility quarterly					
		stated hospice staff performed					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			7. BOILDING.		F	3
		00758	B. WING			3/2014
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ANGELS	CARE CENTER		TH DOW STF FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{2 895}	Continued From pa	ige 8	{2 895}			
	range of motion ext they visited.	ercises to R34's hands when				
	R34 was positioned room with television response to question have bilateral hand hands. During interestant (NA)-G start motion exercises to NA-G stated staff urallow for document exercises.	s on 1/3/14, at 10:50 a.m., d in geriatric chair in resident n on. R34 made no verbal ons. R34 was observed to s contracted with no splints on rview at that time, nursing rated she performed range of o R34's hands that morning. Is se to document range of completed but the new of place on 12/20/13, did not ation of range of motion				
	NA-G pushed R34 dining room. Obse R34's hands were chands. During inteverified R34's hand	in the geriatric chair to Oasis rvations at that time revealed contracted with no splints on rview at that time, NA-G is were contracted and stated to the hand splints applied that				
	Recommendations revealed instruction gentle range of mo	of Occupational Therapy to nursing staff dated 8/16/13, his to wash bilateral hands, tion, fit splints in right and left burs on in the morning and two toon.				
	1/24/13, identified a more independence nursing program, a other programs; #16-dated 1/22/13,	of facility CAA worksheet dated at #2-resident has potential for e with cueing, restorative nd/or task segmentation or identified delirium limits limitation in range of motion.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					3) DATE SURVEY COMPLETED	
		00758	B. WING			R 03/2014
	ANGELS CARE CENTER 300 NOR		DRESS, CITY, S TH DOW STR FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
{2 895}	Continued From pa	ge 9	{2 895}			
	report with print dat care instructions, a instructions for range During interview on of nursing stated the documentation of ralacked interdiscipling motion, lacked range nursing assistants in computer program, discussion of range nursing programs. If acility had not compute residents received nursing verified nur responsible for doc	1/3/14, at 10:50 a.m., director e facility lacked any ange of motion performed, hary notes related to range of ge of motion documentation by n point of care, due to a new and no documentation of of motion and restorative Director of nursing verified the pleted any audits to determine d range of motion. Director of se managers were umenting a monthly note motion and participation in				
	executive director v computer program	1/3/14, at 11:50 a.m., rerified the facility new was effective 12/20/13, and ion for range of motion				
	occupational therap R34 was discharge on 8/15/13, with go instructed nursing s exercises and splin procedure was for o occupational therap nursing staff form wanursing to continue COTA stated she ga	1/3/14, at 1:40 p.m., certified by assistant (COTA) verified d from occupational therapy als met. COTA stated she had staff in range of motion hand ts. COTA stated facility COTA to complete the by recommendations to with therapy instructions for range of motion exercises. ave the recommendation form the clinical manager. COTA				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU A. BUILDING: COMPLE			
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NAME OF I				CTATE ZID CODE	1 01/0	3/2014
	PROVIDER OR SUPPLIER		TH DOW STF	STATE, ZIP CODE REET		
ANGELS	CARE CENTER		FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{2 895}	Continued From pa	ge 10	{2 895}			
		by, she was not aware if by recommendations were				
	report dated 8/26/13 restorative nursing decreased mobility/ range of motion and contractures of han staff to wash bilater motion to both hand, allow finger	f facility resident care plan 3, identified focus of program to decrease risk of contractures; goal to maintain d prevent any further ds; interventions included: ral hands, gentle range of ds, fit splints in right and left room between straps and skin s, staff to apply two times a				
	executive director v monthly clinical man range of motion as correction. Executing lacked evidence of	1/3/14, at 1:45 p.m., rerified the facility lacked mager summary related to written in facility plan of ve director verified the facility range of motion exercises before or after the 12/20/13 em.				
{21015}	MN Rule 4658.0610 Requirements- Sar	O Subp. 7 Dietary Staff nitary conditi	{21015}			
	procedures and cor	conditions. Sanitary nditions must be maintained in dietary department at all				
	by: Uncorrected based	ent is not met as evidenced on the following findings. The der issued on 11/08/13, will				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
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	00758	B. WING		01/0	3/2014
NAME OF PROVIDER OR SUPPLIE	R STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ANGELS CARE CENTER		TH DOW STF FALLS, MN			
(VA) ID SLIMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION)NI	(X5)
PREFIX (EACH DEFICIEN	LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	COMPLETE DATE
{21015} Continued From p	age 11	{21015}			
Based on observative review, the facility environment to provide a subject of the policy of the potential to affacility that had be distributed from the potential to the policy of the	renalty assessment issued. Ition, interview, and document failed to maintain a sanitary event the spread of food borne ded food handling practices, ing, and sanitizing, drying and for resident food use. This had ect 56 of 58 residents in the en provided food prepared and e facility kitchen.				
the noon meal on (DA)-A was obser then held a clip be leg; mixed juice; t glasses as she pl opened the refrigopoured the milk in set out; again oper touched items in change her glove thickener can, tout the spoon into the thickener to the milked with the spoon into the spoon into the thickener to the milked her hands changed the glove of 11:30 a.m. untitouching surfaces resident food or a contaminated sur During an interview stated that she has could not remember	service was observed during 1/2/14 at 11:30 a.m. dietary aid ved to put on gloves. DA-A and and paper; scratched her buched the rim of the drinking aced them on the counter; erator door to get milk and to one of the glass she had just ned the refrigerator door and he refrigerator; DA-A did not as. DA-A then opened the fluid ch the bowl of a spoon, placed thickener and added the ilk. At 11:35 a.m. DA-A then on her apron. DA-A had not as during the observation period 11:35 a.m. while she was that would come in contact with fer touching previously				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.		F	2
		00758	B. WING			3/2014
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ANGELS	CARE CENTER		TH DOW STF			
			FALLS, MN	PROVIDER'S PLAN OF CORRECTION	ON	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{21015}	Continued From pa	ge 12	{21015}			
	the initial kitchen to The dishwasher top was noted to have I when the door was At 12:05 p.m. on 1/2 certified dietary ma observed the debris indicated the area h stated that each tim lifted some debris of and remained on the dishwasher and that time the dishwasher	rocess was observed during ur on 1/2/14 at 10:00 a.m. o above the clean dishes door loose debris that would move opened to remove the dishes. 2/14 the administrator and nager (CDM) had also son top of the dishwasher and nad not been cleaned. CDM he the dishwasher door was came out of the dishwasher he surface on top of the at she did not know the last or surface had been cleaned. Attor and CDM stated that the				
	dietary manager the to the wall and one blowing directly on dishes were remove	2/14 during a tour with the ere were 2 fans (one attached free standing) observed the sanitized dishes after the ed from the dishwasher. CDM e used to help dry the cleaned				
	sanitation dishwash Labs. At 12:05 p.m dishwasher sanitati through 31 2013 was administrator and Conumbers document from 40, 45, 89, 75 guidelines noted on tests range of 10, 5 stated the facility dowith the test strip ra	is a low temperature chemical hing machine provided by ECO in. on 1/2/14 the facility on log for December 18 is reviewed with the CDM. The chemical sanitation sted on the facility log ranged and 50 or 100 while the in the chemical test strips noted in 100, and 200. CDM occumentation did not agree and should be or 100. CDM stated that ECO				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SL A. BUILDING: COMPLE			
				F	₹
	00758	B. WING		01/0	3/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ANGELS CARE CENTER		TH DOW STR FALLS, MN			
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
sanitation was at the that if the sanitation was let the sanitation was problem. CDM stated and test the sanitation numbers were ok. Food preparation equal At 10:25 a.m. on 1/2/dish area with CDM, a observed to have clear an orange substance inside to cover two lated CDM stated this was as part of the food put that the bowl did not hand placed the bowl that the bowl did not hand placed the bowl that the dishwasher again. On 1/2/14 at 12:00 no CDM observed the bowl control of the dishwasher and CD sure what was used the glued area in the administrator stated the removed from sembles of the pipes contained of the covered with dust particular over the cook griddle used for prepared.	the facility to test the ober 2013 to verify the correct level. CDM stated was less than 40, staff were he had not been notified of a d she would look at the logs on levels again, so felt the sipment: 14, while touring the clean a clear plastic bowl was ar tape on the outside and a (looked like glue) on the rege cracks in the bowl. a clean dish and was used are processor. CDM stated have a cleanable surface to run through the con the Administrator and owl of the Rotor puree the processor ready for use. OM verified they were not so glue the bowl crack and bowl. At 12:30 p.m. the che plastic bowl/cover would vice until replaced.	{21015}	DETIGIENCI)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00758	B. WING		01/0	R 03/2014
	PROVIDER OR SUPPLIER	300 NOR	DRESS, CITY, S FH DOW STF FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{21015}	hood, but that it had stated the dust coulduring the cooking staff were to clean to whenever necessar. Review of the check Schedule for Decer 12/29/13 were provided the checklist did not incompanied was MN St. Statute 626.	In not been done since. CDM Id fall into uncovered pots process. CDM stated dietary the walls and range hood ry. Eklist entitled Dietary Cleaning inber 18, 2013 through ided and reviewed. The licate staff cleaning the stove Ils during this time period.	{21015} 21980			
	reporter who has revulnerable adult is to or who has knowled has sustained a phyreasonably explained information to the condividual is a vulne the individual is a drawled admission, unles (1) the individual was another facility and believe the vulnerable previous facility; or (2) the reporter k that the individual is in section 626.5572 (b) A person not provisions of this sas described above	of report. (a) A mandated reason to believe that a peing or has been maltreated, dge that a vulnerable adult report in a solid peing or has been maltreated, dge that a vulnerable adult report the ed shall immediately report the report adult solely because inted to a facility, a mandated red to report suspected individual that occurred prior is: The as admitted to the facility from the reporter has reason to be adult was maltreated in the mows or has reason to believe a vulnerable adult as defined the subdivision 21, clause (4). The required to report under the rection may voluntarily report				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00758	B. WING		01/0	R 3/2014
	PROVIDER OR SUPPLIER	300 NORT	DRESS, CITY, S TH DOW STF FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21980	known or suspected knows or has reason been made to the concept (d) Nothing in this reporter from also reagency. (e) A mandated reason to believe the 626.5572, subdivision. If the retime believes that a agency will determine the reported error with the criteria under set 17, paragraph (c), confacility may provided directly to the lead a how the event meet 626.5572, subdivision (5). The lead agent information when mather report under sufficients with the report under sufficients.	d maltreatment, if the reporter on to know that a report has common entry point. It is section shall preclude a reporting to a law enforcement reporter who knows or has reat an error under section on 17, paragraph (c), clause make a report under this reporter or a facility, at any in investigation by a lead reporter or a facility, at any in investigation by a lead reporter or a section 626.5572, subdivision related to the common entry point or agency information explaining the criteria under section on 17, paragraph (c), clause recy shall consider this reaking an initial disposition of	21980			
	by: Based on observati review, the facility fa allegations of verba director/administrat agency immediately investigation and im prevent further inicc protect the resident conducted for 1 of reviewed for allegat	on, interview and document ailed to immediately report abuse to the executive or nor to the designated state nor complete a thurough aplement interventions to denets from reoccuring and while the investigation was I resident (R6) who was ions of abuse. This had the II 58 residents in the facility.				
	Findinas include:					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			A. BOILDING.		F	3
		00758	B. WING	·		3/2014
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
ANGELS	CARE CENTER		TH DOW STF FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21980	Continued From pa	ge 16	21980			
	without thorough in in place to prevent family member. During observations surveyor heard family state, "Jesu Observations at the wheelchair in the lowere also located in immediately reported coordinator who was this unit and had be					
	this unit and had been located only a few feet from R6. Nurse coordinator had then identified F-A as the one who made the statement to R6. Nurse coordinator then stated F-A had often talked to R6 in this manner quite often in the past. On 1/3/14 at 2:20 p.m. during interview with the social worker (SW) concerning the incident with F-A and R6, SW stated she and the executive director had talked to R6 and F-A concerning the way F-A talked to R6 in a disrespected way. SW also added when she had talked to R6, R6 had not felt it was a problem.					
	Resident Information	n the facility Admission Record on form dated 8/26/10, to have ded diabetes mellitus and ilure.				
	Minimum Data Set 10/23/13, to have in extensive assistant daily living, and had motion functional lin	y the facility on the quarterly (MDS); an assessment dated ntact cognition, required be of one staff for activities of d lower extremity range of mitation on both sides.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE S A. BUILDING: COMPL		E SURVEY PLETED	
					R
	00758	B. WING		01/	03/2014
NAME OF PROVIDER OR SUPP		DDRESS, CITY, S			
ANGELS CARE CENTER		TH DOW STR I FALLS, MN			
PREFIX (EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
aware of F-A's Although exect had talked with verified the fact investigation of they had not redesignated state had not been of the properties of the prope	tor and SW verified they were severbal behavior toward R6. Intive director and SW stated they R6 and F-A in the past, they lity lacked evidence of a thorough the behaviors and also verified ported the verbal behaviors to the reagency before determining it considered verbal abuse. If you on 1/3/14, at 3:00 p.m., tor stated she expected staff to so of alleged verbal abuse to her ean incident report. Executive I there have been no incidents of verbal abuse in the facility and ports of verbal abuse involving R6 and "concerned" about verbal but that she would be "more but physical abuse." R6 stated F-A R6 stated she had lived at the ears and F-A visited her every day. The related the test of the stated of the other. The stated of the other. The stated of the other of the had not done so, if F-A was ear, she would tell family member to be turn of F-A. R6 stated she felt of the nurses to earn of F-A. R6 stated she felt	t			

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		00758	B. WING		01/0	3/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
ANGELS	CARE CENTER		H DOW STF			
040.15	CHIMMADV CTA		FALLS, MN		ON.	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21980	Continued From pa	ge 18	21980			
	spoke to R6 in a " yells at R6 "You never she usually reported worker or registered director, so " some stated she would cathere were no supersocial services or diversity of the incident to the executive director. During interview on housekeeper-A (HS) aware of F-A's belief behavior towards R had occurred for the HSK-A did not get in the she would be some supersonal to the service of the servi	disrespectful " tone, also F-A disrespectful " tone, also F-A der listen to me." R-A stated do this behavior to social donurse manager or executive one can deal with it." R-A all vulnerable adult number if rvisor to notify. R-A stated irector of nursing had not endations to R-A for what to do disrespectfully except to o nurse, director of nursing or 1/3/14, at 3:05 p.m., 6K-A) stated they had been navior of loud, rude and nasty 6. HSK-A stated the behavior e past 2 to 3 weeks and that nvolved. HSK-A stated ed back to F-A during F-A				
	registered nurse (R verbal behavior was sometimes R6 wou RN-C stated if she was abusive from F report to facility soc supervisor, since the evenings. Document review of from 12/18/13 to 1/3 alleged verbal abusing Document review of	1/3/14, at 3:08 p.m., N)-C stated F-A, alleged s just their personality and that ld talk back to family member. did hear something she felt F-A towards R6, RN-C would ital worker or the evening the family member visited in the f facility incident report forms 2/14, revealed no reports of the towards R6. f R6 progress notes dated evealed no evidence of				

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incidents of verbal mistreatment by family

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
			A. BOILDING.		F	2
		00758	B. WING			3/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ANGELS	CAPE CENTER	300 NORT	H DOW STF	REET		
ANGELS CARE CENTER CANNON		CANNON	FALLS, MN	55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21980	Continued From pa	ge 19	21980			
	member.					
	Document review or revealed focus reside by staff and/or othe physical mobility. Cowould be protected Interventions includ report to staff if reside bothered by other replan lacked interver behaviors by family. Document review of Process policy revision following: Procedured involving a resident surrounding the including and skin teat allegation of injury, and/or maltreatment suspicious death of includes allegations and incidents of allegations. Follow all immediates including immediates and for Social Services. 5. The Executive Dand for Social Services and for Social Services	f facility Resident Incident sed dated 7/13, revealed the re: con witnessing or being ent, incident or altercation, an investigation of the facts ident is initiated. Any fall, reknown origin, (including ears) medication errors, allegation of abuse, neglect at, self-abuse/suicide attempt, a resident, elopement (this of resident to resident abuse eged financial exploitation) will he Risk Management R. Rediate reporting and notification adated reporting and elder ions of alleged abuse/neglect, e notification to the Executive Director, Director of Nursing ice Director and IDT res that appropriate follow-up,				

Minnesota Department of Health

	ta Department of Tie				ı	
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					R	
		00758	B. WING			3/2014
		00730			01/0	3/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
411051.0	OADE OFNITED	300 NORT	H DOW STF	REET		
ANGELS	CARE CENTER	CANNON	FALLS, MN	55009		
(X4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION)N	(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIES	PRIATE	DATE
				DEFICIENCY)		
21980	Continued From pa	ne 20	21980			
	·					
		ement interventions for safety				
	to prevent reoccurre	ence.				
	Document review o					
		icipant Protection Policy and				
		dated 12/12, directed staff the				
	following: page 5: #					
		complaint of alleged				
		D (executive director),				
		designee and Social services				
		ordinate an investigation,				
		ompletion of witness				
	statements.					
		ved including two of the				
		dent/client/participants or				
		ootentially involved, or				
		ed incident are to be				
		DON, Social services or				
		nts should be written on the				
		form. Interviews should be				
		aff members present				
	whenever possible/					
		plement appropriate				
	consultation.	ncreased 1:1, psychological				
		an and written findings are				
		on and written findings are				
	•	ewed with the Executive				
	other officials in acc	gnated representative, and to				
		further action is determined				
	with input from app					
		he Investigative Data Sheet				
		nt further occurrences				
	as specified per					
		ce will investigate all alleged				
	violations and will p					
		while the investigation is in				
	•	withe the hivestigation is in				
	progress.					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			,	
00758		B. WING		01/0	3/2014		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
ANGELS	CARE CENTER		H DOW STF				
			FALLS, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21980	Continued From pa	ge 21	21980				
21900	Page 6: #4. Reporti Individuals: a. Who must report a resident/client/particexternal business who: (continued on Has knowledge a resident/client/particexternal business who: (continued on Has knowledge a resident/client/particexternal business who: (continued on Has reasonable resident/client/particexternal business who: (continued on Has reasonable resident/client/particexternal business who is the profacility/service? 1. After safeguaresident/client/particexternal business with a supervisor immedia Director/or designa officials in accordar contacted immediar regarding all allegal Immediate reporting mail, answering main and time of notification. Page 10: E. Definition Abuse/Mistro of injury, unreasona intimidation, physical harm, pain Page 11: #5. Verbate The use of clanguage that willfur derogatory to resident/client/particexternal particexternal particextern	ing Maltreatment of ort suspected maltreatment of rticipant? Any employee, cipant, family/guardian, rendor or entity, or volunteer page 7) of suspected maltreatment of rticipant. It cause to believe that a cipant has been maltreated. In order for reporting within the carding the cipant (and all residents) as so, report the information to the ately. The Executive ted representative (and other nace with state law) must be tely by Supervisor or reporter tions of abuse/neglect. If may be reported via voice uchine, or fax. Document date tion. It is of Abuse and Neglect: eatment is the willful infliction able confinement, or punishment with resulting and permit or mental anguish. It is also as a confinement or gestured and the c	21900				

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Minnesota Department of Health

AND BLAN OF CORRECTION TO TRENTIFICATION NUMBERS		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILDING.		F	3
		00758	B. WING			3/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ANGELS	CARE CENTER		TH DOW STF FALLS, MN			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
	#6. Use of written or gestured vulnerable a vulnerable adult what a reasonable derogatory, humilia threatening. During interview on executive directors had occurred on-go October 2013, at with the area. Executive aware of any incide behaviors toward on had "sworn" at staff of and executive directors and executive directors.	adult or the treatment of a nich would be considered by le person to be disparaging, ting, harassing, or				
	conversation with F she talked with the "either the last wee week of December R6's situation. Ex was no documenta Executive director sincident reports relabehaviors. Executi had not reported R6F-A to the office of behavior had been verified the facility I of the ongoing allegin regards to R6. Exany allegation of abreported to her imm	"-A. Executive director stated "Ombudsman" one time k of November 2013 or first 2013" in regards to F-A and ecutive director verified there tion of this conversation either. Stated the facility had no ated to F-A's alleged verbal ve director stated the facility 6's alleged verbal abuse by health facility (OHFC) as this ongoing. Executive director acked a thorough investigation gation of verbal abuse by F-A executive director than said that buse of any type is to be				

6899

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
					F	?	
		00758	B. WING		01/0	3/2014	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
ANGELS	CARE CENTER		TH DOW STF FALLS, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE	
	MN St. Statute 626 Maltreatment of Vul Subd. 3a. Report events are not requisection: (a) A circumstant specifically prohibits patient identifying in report of suspected vulnerable adult, or guardian, conserva has consented to d conforms to federal whose patients or re a federal law shall of suspected maltre resident, or a guard representative, upo admission to the far prohibited by federal incident of suspect immediately seek c (b) Verbal or phy- between patients, re or self-abusive behavi licensing agencies agencies. (c) Accidents as subdivision 3.	.557 Subd. 3a Reporting -	21985		TIMIE		
		in the provision of therapeutic					

6899

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00758	B. WING		01/0	R 03/2014
	PROVIDER OR SUPPLIER	300 NORT	DRESS, CITY, S TH DOW STF FALLS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
21985	section 626.5572, s 17, paragraph (c), (e) Nothing in this require a report of fidefined in section 6 on the basis of the by gift or as compell. This MN Requirements by: Based on observation review, the facility farewiew, the facility farewiew, the facility farewiew, the facility farewiew which income to be immediated director, reported to failed to initiate an implement intervent (R6) observed for with the facility who were staff failure to imple findings include: R6 experienced onfrom a family (F)-A eleven weeks with director notification, agency notification, investigation, and with protect R6 from one according to facility.	able adult, as provided in subdivision clause (4). Is section shall be construed to inancial exploitation, as 626.5572, subdivision 9, solely transfer of money or property insation for services rendered. In the services rendered on, interview and document alled to implement their process and icipant Protection Policy and dicated allegations of abuse ately reported to the executive of the designated state agency, investigation, and failed to the executive of the designated state agency, investigation, and failed to the executive of the treatment. This had contain the policies. In the services are also to the executive of the designated state agency, investigation, and failed to the executive of the executive	21985			
		f facility Resident Incident sed dated 7/13, revealed the				

6899

	<u>ita Department of He</u>	ailii				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00758	B. WING	B. WING		≀ 3/2014
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
			H DOW STR			
ANGELS	CARE CENTER		FALLS, MN			
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE		
21985	following: Procedur 1. Immediately up notified of an accide involving a resident surrounding the inc injury of unknown of bruises and skin tea allegation of injury, and/or maltreatment suspicious death of includes allegations and incidents of alle be documented in t Program of the EMI 3. Follow all immed procedures for man justice act for situat including immediate Director. 5. The Executive D and /or Social Service Designees ensu notifications, and in completed with t the follow-up.	re: con witnessing or being ent, incident or altercation , an investigation of the facts ident is initiated. Any fall, r known origin, (including ears) medication errors, allegation of abuse, neglect at, self abuse/suicide attempt, a resident, elopement (this e of resident to resident abuse eged financial exploitation) will the Risk Management R. ediate reporting and notification adated reporting and elder ions of alleged abuse/neglect, e notification to the Executive director, Director of Nursing ice Director and IDT ures that appropriate follow-up, vestigation is the incident, and documents ement interventions for safety	21985	DETIGIENCI)		
	Procedure revised of following: page 5: # a. Upon receiving maltreatment, the E Director of Nursing/or designee will cool	icipant Protection Policy and dated 12/12, directed staff the				

STATE FORM 6899 If continuation sheet 26 of 29 ETLH12

Minnesota Department of Health		1				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					F	3
		00758	B. WING			3/2014
		00.00			01/0	3/201 4
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ANCELO	CARE CENTER	300 NOR1	TH DOW STE	REET		
ANGELS	CARE CENTER	CANNON	FALLS, MN	55009		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION)N	(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE	DATE
				DEI IOIENOT)		
21985	Continued From pa	ge 26	21985			
		dent/client/participants or				
		ootentially involved, or				
		ed incident are to be				
		DON, Social services or				
		ents should be written on the				
		Form. Interviews should be				
		aff members present				
	whenever possible/					
		plement appropriate				
		ncreased 1:1, psychological				
	consultation.	an and written findings are				
		on and written findings are				
		ewed with the Executive				
	other officials in acc	gnated representative, and to				
	with input from app	urther action is determined				
		he Investigative Data Sheet				
		nt further occurrences				
	as specified per					
		ce will investigate all alleged				
	violations and will p					
		while the investigation is in				
	progress.	write the investigation is in				
	progress.					
	Page 6: #4. Reporti	ing Maltreatment of				
	Individuals:	ing Main cannoth of				
		ort suspected maltreatment of				
		rticipant? Any employee,				
		cipant, family/guardian,				
		rendor or entity, or volunteer				
	who: (continued on					
		of suspected maltreatment of				
	a resident/client/par					
		e cause to believe that a				
		cipant has been maltreated.				
		cedure for reporting within the				
	facility/service?	Total of topoling within the				
	After safeguard	ing the				
		cipant (and all residents) as				

Minnesota Department of Health

STATE FORM 6899 ETLH12 If continuation sheet 27 of 29

AND BLAN OF CORRECTION TO THE TOTAL NUMBER.		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILDING.		R	
		00758	B. WING			3/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ANGELS	CARE CENTER		TH DOW STF FALLS, MN			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21985	well as his/her right supervisor immedia Director/or designa officials in accordar contacted immedia regarding all allega Immediate reporting mail, answering ma and time of notificar Page 10: E. Definit Abuse/Mistre of injury, unreasona intimidation, physical harm, pain Page 11: #5. Verba The use of clanguage that willfur derogatory resident/client/partic within their hearing distance, recomprehend, or distance, recomprehend, or distance vulnerable adult who by a reaso disparaging, derogatory or threatening. During interview on registered nurse-B	s, report the information to the ately. The Executive ted representative (and other nee with state law) must be tely by Supervisor or reporter tions of abuse/neglect. It is may be reported via voice achine, or fax. Document date tion. Stions of Abuse and Neglect: eatment is the willful infliction able confinement, or punishment with resulting and terms to cipants or their families, or gardless of their age, ability to ability. In all abuse: or gestured and terms to cipants or their families, or gardless of their age, ability to ability. In all abuse: or gestured and terms to cipants or their families, or gardless of their age, ability to ability. In all abuse: or gestured and terms to cipants or their families, or gardless of their age, ability to ability.	21985			
	R6's family memb	er's behavior. RN-B verified talked loud, rude and nasty to				

Minnesota Department of Health

STATE FORM 6899 ETLH12 If continuation sheet 28 of 29

AND DUAN OF CODDECTION IDENTIFICATION NUMBER.			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
	00758		B. WING			R 01/03/2014	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	01/0	J3/2014	
ANGELS	CARE CENTER		TH DOW STF FALLS, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
21985	Continued From pa	ge 28	21985				
21985	other residents. RN occurred for a coup reported the behavi and administrator. During interview on executive director shad occurred on-go October 2013, at will had moved into the stated she expected alleged abuse to he	I-B stated the behavior had ble months. RN-B stated had ior to facility social services 1/3/14, at 3:45 p.m., stated F-A's verbal behaviors bing since the middle of hich time the family member area. Executive director d staff to report all incidents of	21985				
i							

6899

2000 CODE

Form Approved OMB Exempt

FIRE SAFETY SURVEY REM	PORT 2000 COD are – Medicaid	E - HEALTH CA	KE ` `	PROVIDER NUI 5304	//BER 1. (B) M	EDICAID I.D. NO.
		ART I — Life Safety C ART IV — Waiver R			•	
Identifying information as shown in appli	icable records. Enter	changes, if any, alo	ngside each ite	m, giving dat	e of change.	
2. NAME OF FACILITY		TRUCTION (BLDGS) 2				ZIP CODE) A Fully Sprinklered
ANGELS CARE CENTER	A. BUILDING B. WING C. FLOOR	01	300 NORTH CANNON F	H DOW ST	REET	B. Partially Sprinklered (Not all required areas are sprinklered C. None (No sprinkler system)
3. SURVEY FOR	4. DATE OF SURVEY		DATE OF PLAN AF	PROVAL	SURVEY UNDER	T KO160
✓ MEDICARE ✓ MEDICAID	11/05/2013	k	36		5. 000 EXISTIN	G 6. 2000 NEW
5. SURVEY FOR CERTIFICATION OF	104	1.			K/	
1 HOSPITAL 2. SKILLED/NU	IRSING FACILITY	4. OCF/MR UND	ER HEALTH CAR	E 5.	HOSPICE	
IF "2" OR "5" ABOVE IS MARKED, CHECK APPR 1. ENTIRE FACILITY 2. ISTINCT PA	ROPRIATE ITEM(S) BELO ART OF (SPECIFY)	ow			NCT PART OF HOSPIT	TAL, IS HOSPITAL ACCREDITED?
6. BED COMPOSITION						
	HOSPITAL BEDS OR MEDICARE 0	NUMBER OF SKILLED E CERTIFIED FOR MEDIC	BEDS 89 d.	NUMBER OF SECENTIFIED FOR	KILLED BEDS MEDICAID_89	e. NUMBER OF NF or ICF/MR BEDS O CERTIFIED FOR MEDICAID
7. A THE FACILITY MEETS, BASED UPON	(CHECK ALL APPROPR	IATE BOXES)				
1. OCOMPLIANCE WITH ALL PROVIS	_	,	RECTION 3	ECOMMENDED	WAIVEDS A CO	ES 5 PERFORMANCE BASED DESIGN
B. THE FACILITY DOES NOT MEET THE		102 01 711 2 111 01 00111	EUTION 0.	ILOOMINIL(VDLD	WAIVERS 403	LO SOPERFORMANCE BASED DESIGN
SURVEYOR (Signature)	TITLE		OFFICE			DATE
SURVEYOR ID 25822 Deputy State Fire Marshal			State Fire Marshal		11/052013	
FIRE AUTHORITY OFFICIAL (Signature)	TITLE		OFFICE			DATE
73	Fire Safety	Supervisor	State F	ire Marsha		11-19-13

ID PREFIX		MET	NOT MET	N/A	REMARKS
	PART I - LSC REQUIREMENTS - Items in italics relate to the FSES				K11 - 2 hour building separation between Nursing home
	BUILDING CONSTRUCTION				Type II and Chapel Type V building.
K11	If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 1½ hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2		0	0	
K12	2000 EXISTING				K12 -
	Building construction type and height meets one of the following: 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1	0	0	0	1977 - Original 1-story - no basement
	1 I (443), I (332), II (222) Any Height				1982 - Addition 1-story - no basement 1985 - Addition 1-story - no basement
	2 One story only (non-sprinklered).				1905 - Addition 1-story - no basement
	Not over three stories with complete automatic sprinkler system.				
	4 O III (211)				×
	5 V (111) Not over two stories with complete automatic				
	6 OIV (2HH) sprinkler system.				
	7 11 (000)				
	8 III (200) Not over one story with complete automatic				
	9 V (000) sprinkler system.	865			
ļ	Building contains fire treated wood. Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.				

					NOT		
ID PREFIX				MET	NOT MET	N/A	REMARKS
K12		00 NEW					
		lding construction type and height 1.6.2, 18.1.6.3, 18.3.5.1.	t meets one of the following:				
	10.	1.0.2, 10.1.0.3, 10.3.3.1.					
	1	I (443), I (332), II (222)	Any height with complete automatic sprinkler system				
	2	II (111)	Not over three stories with complete automatic sprinkler system	_			
	3	III (211)					
	4	V (111)	Not over one story with complete automatic				
	5	IV (2HH)	sprinkler system.				
	6	II (000)					
	7	III (200)	Not Permitted				
	8	V (000)	TVOCT CHINICOL				
	☐ Building contains fire treated wood. Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.						
K103	Interior walls and partitions in buildings of Type I or Type II construction shall be noncombustible or limited-combustible materials. 18.1.6.3, 19.1.6.3						
	(Indicate N/A for existing buildings using listed fire retardant treated wood studs within non-load bearing one-hour rated partitions.)						

ID		MET	NOT	N/A	REMARKS
PREFIX	INTERIOR FINIOU	IVILI	MET	IN/A	TILMATIKO
	INTERIOR FINISH				
K14	2000 EXISTING Interior finish for means of egress, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. Interior finishes existing before December 17, 2010 that are applied directly to wall and ceilings with a thickness of less than ½8 inch shall be permitted to remain in use without flame spread rating documentation. 10.2, 19.3.3.1, 19.3.3.2, NFPA TIA 00-2 Indicate flame spread rating/s				
	2000 NEW Interior finish for means of egress, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. Lower half of corridor walls, not exceeding 4ft in height, may have a Class C flame spread rating. 10.2, 18.3.3.1, 18.3.3.2, NFPA TIA 00-2 Indicate flame spread rating/s				
K15	2000 EXISTING Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. (In fully-sprinklered buildings, flame spread rating of Class C may be continued in use within rooms separated in accordance with 19.3.6 from the exit access corridors.) 19.3.3.1, 19.3.3.2 Indicate flame spread rating/s				
	2000 NEW Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. (Rooms not over 4 persons in capacity may have a flame spread rating of Class A, Class B, or Class C). 18.3.3.1, 18.3.3.2. Indicate flame spread rating/s				

ID PREFIX		MET	NOT MET	N/A	REMARKS
(16	2000 EXISTING Newly installed interior floor finish complying with 10.2.7 shall be permitted in corridors and exits if Class I. 19.3.3.3 In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, no interior floor finish requirements shall apply.				
	CORRIDOR WALLS AND DOORS				
K17	Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2, 19.3.6.4, 19.3.6.5 If the walls have a fire resistance rating, give rating if the walls terminate at the underside of a ceiling, give a brief description in REMARKS, of the ceiling, describing the ceiling throughout the floor area.				
	2000 NEW Corridor walls shall form a barrier to limit the transfer of smoke. Such walls shall be permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. No fire resistance rating is required for the corridor walls. 18.3.6.1, 18.3.6.2, 18.3.6.4, 18.3.6.5				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K18	Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3		IVIL I		
	Show in REMARKS, details of doors, such as fire protection ratings, automatic closing devices, etc.				
	2000 NEW Doors protecting corridor openings shall be constructed to resist the passage of smoke. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches shall be prohibited. 18.3.6.3				
	Show in REMARKS, details of doors, such as fire protection ratings, automatic closing devices, etc.				
K19	Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) In other than smoke compartments containing patient bedrooms, miscellaneous opening are permitted in vision panels or doors provided the aggregate area of the opening per room does not exceed 20 in.² and the opening is installed in bottom half of the wall (80 in.² in fully sprinklered buildings). 18.3.6.5, 19.3.6.2.3, 19.3.6.3.8, 19.3.6.5				
	40.0700P (00/0040)				

ID PREFIX		MET	NOT MET	N/A	REMARKS
	VERTICAL OPENINGS				
K20	2000 EXISTING				
	Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5, 8.2.5.6, 19.3.1.1 If all vertical openings are properly enclosed with construction providing at least a two hour fire resistance rating, also check this box.				
	If enclosures are less than required, give a brief description and specific location in REMARKS.				
	2000 NEW				
	Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least two hours connecting four stories or more. (One hour for single story building and buildings up to three stories in height.) An atrium may be used in accordance with 8.2.5.6, 8.2.5, 18.3.1.1.				
	If enclosures are less than required, give a brief description and specific location in REMARKS.				
K21	Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of:				
	 □ (a) The required manual fire alarm system and □ (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and 				
	☐ (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2				
	Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1				
	Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed.				

			NGT	_
ID PREFIX		MET	NOT MET	N/A
	Describe method used in REMARKS			
	SMOKE COMPARTMENTATION AND CONTROL			
K23	2000 EXISTING			
	Smoke barriers shall be provided to form at least two smoke compartments on every sleeping room floor for more than 30 patients. 19.3.7.1, 19.3.7.2			
	2000 NEW Smoke barriers shall be provided to form at least two smoke compartments on every floor used by inpatients for sleeping or treatment, and on every floor with an occupant load of 50 or more persons, regardless of use. Smoke barriers shall also be provided on floors that are usable, but unoccupied. 18.3.7.1, 18.3.7.2			
K24	The smoke compartments shall not exceed 22,500 square feet and the travel distance to and from any point to reach a door in the required smoke barrier shall not exceed 200 feet. 18.3.7.1, 19.3.7.1			
	Detail in REMARKS zone dimensions including length of zones and dead end corridors.			
K25	2000 EXISTING			
	Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5			
	2000 NEW			
	Smoke barriers shall be constructed to provide at least a one hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels in approved frames. 8.3, 18.3.7.3, 18.3.7.5			
K26	Space shall be provided on each side of smoke barriers to adequately accommodate the total number of occupants in adjoining compartments. 18.3.7.4, 19.3.7.4			
	MO 0700D (00/0040)			

ID PREFIX				MET	NOT MET	N/A	REMARKS
K27	2000 EXISTING Doors in smoke barriers rating or are at least 1¾ Non-rated protective plathe bottom of the door a comply with 7.2.1.14. Do closing in accordance wirequired to swing with exprequired. 19.3.7.5, 19.3.	inch thick solid to tes that do not exercised. However, pors shall be self th 19.2.2.2.6. Swaress and positive	oonded core wood. xceed 48 inches from rizontal sliding doors -closing or automatic- vinging doors are not				
	2000 NEW Doors in smoke barriers have rating or are at least 1¾ in rated protective plates that of the door are permitted. 7.2.1.14. Swinging doors in an opposite direction. Devels or astragals are relatching is not required.	nch thick solid bor at do not exceed 4 Horizontal sliding shall be arranged Doors shall be self quired at the mee	nded core wood. Non- 8 inches from the bottom doors comply with so that each door swings -closing and rabbets, ting edges. Positive				
K28	2000 EXISTING Door openings in smoke width of 32 inches (81 cr 19.3.7.7						_
	2000 NEW Door openings in smoke horizontal doors shall pro						
	Provider Type	Swinging Doors	Horizontal Sliding Doors				
	Hospitals and Nursing Facilities	41.5 inches (105 cm)	83 inches (211 cm)				
	Psychiatric Hospitals and Limited Care Facilities	32 inches (81 cm)	64 inches (163 cm)				
	18.3.7.7						

Penetrations of smoke barriers by ducts are protected in accordance with 8.3.5. Dampers are not required in duct penetrations of smoke barriers in fully ducted HVAC systems where a sprinkler system in accordance with 18/19.3.5 is provided for adjacent smoke compartments. 18.3.7.3, 19.3.7.3. Hospitals may apply a 6-year damper testing interval conforming to NFPA 80 & NFPA 105. All other health care facilities must maintain a 4-year damper maintenance interval. 8.3.5 Describe any mechanical smoke control system in REMARKS. HAZARDOUS AREAS 2000 EXISTING One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Area							
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a. Boiler and Fuel-Fired Heater Rooms c. Laundries (greater than 100 sq feet) d. Repair Shops and Paint Shops e. Laboratories (if classified a Severe Hazard - see K31) f. Combustible Storage Rooms/Spaces (over 50 sq feet) g. Trash Collection Rooms i. Soiled Linen Rooms	Aroa	Automatic Sprinkler	Sonaration N/A				
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i. Soiled Linen Rooms	f. Combustible Storage Rooms/Spaces (over 50 sq feet)						
	i. Soiled Linen Rooms						
	are deficient in REMARKS.						
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	2000 NEW					
	Hazardous areas are protected in accord	ance with 8.4. The				
	areas shall be enclosed with a one hour t	fire-rated barrier, with a				
	3/4 hour fire-rated door, without windows (in accordance with				
	8.4). Doors shall be self-closing or autom					
	accordance with 7.2.1.8. Hazardous area					
	sprinkler system in accordance with 9.7,	18.3.2.1, 18.3.5.1.				
	Area Automa	atic Sprinkler Separation N/A				
	a. Boiler and Fuel-Fired Heater Rooms	and opinines deparation 1471				
	c. Laundries (greater than 100 sq feet)					
	d. Repair, Maintenance and Paint Shops					
	e. Laboratories (if classified a Severe Hazard - see K31)					
	f. Combustible Storage Rooms/Spaces					
	(over 50 and less than 100 sq feet) g. Trash Collection Rooms					
	i. Soiled Linen Rooms					
	m. Combustible Storage Rooms/Spaces (over 100 sq feet)					
	Describe the floor and zone locations of ha	zardous areas that				
	are deficient in REMARKS.					
	are denoted in right into.					
K30	Gift shops shall be protected as hazardou	us areas when used for				
	storage or display of combustibles in qua					
	hazardous. Non-rated walls may separate					
	considered hazardous, have separate pro					
	are completely sprinkled. Gift shops may					
	if they are not considered hazardous, hav	e separate protected				
	storage, are completely sprinklered and c	lo not exceed 500				
	square feet. 18.3.2.5, 19.3.2.5					
	- equal o 10011 10101210, 10101210					
	Area Automa	tic Sprinkler Separation N/A				
	L. Gift Shop storing hazardous quantities					
	of combustibles					

			NOT		
ID PREFIX		MET	NOT MET	N/A	REMARKS
K211	Where Alcohol Based Hand Rub (ABHR) dispensers are installed: The corridor is at least 6 feet wide The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) The dispensers shall have a minimum spacing of 4 ft from each other Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. Dispensers are not installed over or adjacent to an ignition source. If the floor is carpeted, the building is fully sprinklered. 18.3.2.7, CFR 403.744, 418.110, 460.72, 482.41, 483.70, 485.623				
	EXITS AND EGRESS				
K22	Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. Doors, passages or stairways that are not a way of exit that are likely to be mistaken for an exit have a sign designating "No Exit". 7.10, 18.2.10.1, 19.2.10.1				
K32	Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Not less than one exit from each floor or fire section shall be a door leading outside, stair, smoke-proof enclosure, ramp, or exit passageway. Only one of these two exits may be a horizontal exit. Egress shall not return through the zone of fire origin. 18.2.4.1, 18.2.4.2, 19.2.4.1, 19.2.4.2				
K33	2000 EXISTING Exit enclosures (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 7.1.3.2, 8.2.5.2, 8.2.5.4, 19.3.1.1				
	If all vertical openings are properly enclosed with construction providing at least a two hour fire resistance rating, also check this box. □				
	If enclosures are less than required, give a brief description and specific location in REMARKS.				
	l				4

ID MET NOT N/A	
PREFIX MET N/A	
2000 NEW	
Exit enclosures (such as stairways) in buildings four stories or	
more are enclosed with construction having a fire resistance rating of at least two hours, are arranged to provide a continuous	
path of escape, and provide a protection against fire and smoke	
from other parts of the building. In all buildings less than four	
stories, the enclosure is at least one hour. 7.1.3.2, 8.2.5.2,	
8.2.5.4, 18.3.1.1, 18.2.2.3	
If enclosures are less than required, give a brief description and specific location in REMARKS.	
K34 Stairways and smokeproof enclosures used as exits are in	
accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4	
K35 The capacity of required mean of egress is based on its width, in accordance with 7.3.	
K36 Travel distance (exit access) to exits are measured in	
accordance with 7.6.	
Room door to exit ≤ 100 ft (≤ 150 ft sprinklered)	
 Point in room or suite to exit ≤ 150 ft (≤ 200 ft sprinklered) 	
• Point in room to room door ≤ 50 ft	
• Point in suite to suite door ≤ 100 ft 18.2.6, 19.2.6	
K37 2000 EXISTING	
Existing dead-end corridors shall be permitted to be continued to be used if it is impractical and unfeasible to alter them so that	
exists are accessible in not less than two different directions	
from all points in aisles, passageways, and corridors. 19.2.5.10	
2000 NEW	
Every exit and exit access shall be arranged so that no corridor,	
aisle or passageway has a pocket or dead-end exceeding 30 feet, 18.2.5.10	
K38 Exit access is so arranged that exits are readily accessible at all times in accordance with 7.1. 18.2.1, 19.2.1	
K39 2000 EXISTING	
Width of aisles or corridors (clear and unobstructed) serving as exit access shall be at least 4 feet. 19.2.3.3	
Extractess shall be at least 4 leet. 19.2.3.3	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	2000 NEW				
	Width of aisles or corridors (clear and unobstructed) serving as exit access in hospitals and nursing homes shall be at least 8 feet. In limited care facility and psychiatric hospitals, width of aisles or corridors shall be at least 6 feet. 18.2.3.3, 18.2.3.4				
K40	2000 EXISTING				
	Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 32 inches in clear width. An exception is provided for existing 34-inch doors in existing occupancies. 19.2.3.5				
	2000 NEW				
	Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 41.5 inches in clear width Doors in exit stairway enclosures shall be no less than 32 inches in clear width. In psychiatric hospitals or limited care facilities (e.g.,ICF/MD providing medical treatment) doors are at least 32 inches wide. 18.2.3.5				
K41	All sleeping rooms have a door leading to a corridor providing access to an exit or have a door leading directly to grade. One room may intervene in accordance with 18.2.5.1, 19.2.5.1 If doors lead directly to grade from each room, check this box.				
K42	Any patient sleeping room or suite of rooms of more than 1,000 sq. ft. has at least 2 exit access doors remote from each other. 18.2.5.2, 19.2.5.2				
K43	Patient room doors are arranged such that the patients can open the door from inside without using a key.				
	Special door locking arrangements are permitted in facilities. 18.2.2.2.4, 18.2.2.2.5, 19.2.2.2.4, 19.2.2.2.5				
	If door locking arrangement without delay egress is used indicate in REMARKS 18.2.2.2.2, 19.2.2.2.2				
K44	Horizontal exits, if used, are in accordance with 7.2.4. 18.2.2.5, 19.2.2.5				
K47	Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1, 19.2.10.1				
	(Indicate N/A in one story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)				

		Т		
ID PREFIX		MET	NOT MET	N/A
K72	Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1			
	ILLUMINATION			
K45	Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture will not leave the area in darkness. Lighting system shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8, 7.8			
K46	Emergency lighting of at least 1½ hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1.			
K105	2000 NEW (INDICATE N/A FOR EXISTING)			
	Buildings equipped with or requiring the use of life support systems (electro-mechanical or inhalation anesthetics) have illumination of means of egress, emergency lighting equipment, exit, and directional signs supplied by the Life Safety Branch of the electrical system described in NFPA 99. 18.2.9.2., 18.2.10.2 (Indicate N/A if life support equipment is for emergency purposes only).			
	EMERGENCY PLAN AND FIRE DRILLS	1	1	I
K48	There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1, 19.7.1.1			
K50	Fire drills include the transmission of a fire alarm signal and simulation of emergency fire 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. 18.7.1.2, 19.7.1.2			

———ID			NOT		
PREFIX		MET	NOT MET	N/A	REMARKS
	FIRE ALARM SYSTEMS				
K51	A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6				
K52	A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7,				
K155	Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8				
K53	2000 EXISTING (INDICATE N/A FOR HOSPITAL AND FULLY SPRINKLERED NURSING HOMES) In an existing nursing home, not fully sprinklered, the resident sleeping rooms and public areas (dining rooms, activity rooms, resident meeting rooms, etc) are to be equipped with single station battery-operated smoke detectors. There will be a testing, maintenance and battery replacement program to ensure proper operation. CFR 483.70				
	40 0700D (00 (0040)				Doge 16

ID PREFIX		MET	NOT MET	N/A	REMARKS
	2000 NEW (NURSING HOME AND EXISTING LIMITED CARE FACILITIES) An automatic smoke detection system is installed in all corridors. (As an alternative to the corridor smoke detection system on patient sleeping room floors, smoke detectors may be installed in each patient sleeping room and at smoke barrier or horizontal exit doors in the corridor.) Such detectors are electrically interconnected to the fire alarm system. 18.3.4.5.3				
K109	2000 EXISTING LIMITED CARE FACILITIES (INDICATE N/A FOR HOSPITALS OR NURSING HOMES) An automatic smoke detection system is installed in all corridors with detector spacing no further apart than 30 ft on center in accordance with NFPA 72. (As an alternative to the corridor smoke detection system on patient sleeping room floors, smoke detectors may be installed in each patient sleeping room and at smoke barrier or horizontal exit doors in the corridors.) Such detectors are electrically interconnected to the fire alarm system. 19.3.4.5.1 Smoke Detection System □ Corridors □ Rooms				
K54	All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 Give a brief description, in REMARKS of any smoke detection system which may be installed.				
K55	2000 EXISTING Every patient sleeping room shall have an outside window or outside door. Except for newborn nurseries and rooms intended for occupancy for less than 24 hours. 19.3.8 2000 NEW Every patient sleeping room shall have an outside window or outside door. The allowable sill height shall not exceed 36 inches (91 cm) above the floor. Windows are not required for recovery rooms, newborn nurseries, emergency rooms, and similar rooms				

ID		MET	NOT	N/A	REMARKS
PREFIX	intended for occupancy for less than 24 hours. Window sill height for limited care facilities shall not exceed 44 inches (112 cm) above the floor. 18.3.8		MET		
(60	Initiation of the required fire alarm systems shall be by manual fire alarm initiation, automatic detection, or extinguishing system operation. 18.3.4.2, 19.3.4.2, 9.6.2.1				
	AUTOMATIC SPRINKLER SYSTEMS				
56	2000 EXISTING				
	Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13				
	2000 NEW				
	There is an automatic sprinkler system installed in accordance with NFPA13, Standard for the Installation of Sprinkler Systems, with approved components, device and equipment, to provide complete coverage of all portions of the facility. Systems are equipped with waterflow and tamper switches, which are connected to the fire alarm system. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 18.3.5, 18.3.5.1.				
154	Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch system be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1.				
	A. Date sprinkler system last checked and necessary maintenance provided				

		_		
ID PREFIX		MET	NOT MET	N/A
	B. Show who provided the service			
	C. Note the source of water supply for the automatic sprinkler system.			
	(Provide, in REMARKS, information on coverage for any non-required or partial automatic sprinkler system.)			
K61	Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72			
K62	Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5			
K63	Required automatic sprinkler systems have an adequate and reliable water supply which provides continuous and automatic pressure. 9.7.1.1, NFPA 13			
K64	Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6			
	SMOKING REGULATIONS			
K66	Smoking regulations shall be adopted and shall include not less than the following provisions: 18.7.4, 19.7.4, 8-6.4.2 (NFPA 99)			
	(1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the internationa symbol for no smoking.			
	Exception: In facilities where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs that prohibit smoking in use areas are not required. (Note: This exception is not applicable to medical gas storage areas.) 8-3.1.11.3 (NFPA 99)			

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ID PREFIX		MET	NOT MET	N/A	REMARKS
	(2) Smoking by patients classified as not responsible shall be prohibited, except when under direct supervision.				
	(3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.				
	(4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.				
	BUILDING SERVICE EQUIPMENT				
K67	Heating, ventilating, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2, NFPA 90A, 18.5.2.2, 19.5.2.2				
K68	Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 18.5.2.2, 19.5.2.2.				
K69	Cooking facilities shall be protected in accordance with 9.2.3. 18.3.2.6, 19.3.2.6, NFPA 96				
K70	Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C). 18.7.8, 19.7.8				
K71	Rubbish Chutes, Incinerators and Laundry Chutes. 18.5.4, 19.5.4, 9.5, 8.4, NFPA 82				
	(1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1 hour. All new chutes shall comply with 9.5.				
	(2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7.				
	(3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4.				

ID			NOT		
PREFIX		MET	NOT MET	N/A	REMARKS
	(4) Existing flue-fed incinerators shall be sealed by fire resistive construction to prevent further use.				
K160	2000 EXISTING				
	Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in A17.1, Safety Code for Elevators and Escalators. Fire Fighter's Service is operated monthly with a written record.				
	Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators & Escalators. All existing elevators, having a travel distance of 25 ft or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. 9.4.2, 9.4.3, 19.5.3				
	(Includes firefighters service phase I key recall and smoke detector automatic recall, firefighters service phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.)				
	2000 NEW				
	Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in A17.1, Safety Code for Elevators and Escalators. Fire Fighter's Service is operated monthly with a written record.				
	New elevators conform to ASME/ANSI A17.1, Safety Code for Elevators and Escalators, including Fire Fighter's Service Requirements. 9.4.2, 9.4.3, 18.5.3				
	(Includes firefighters service phase I key recall and smoke detector automatic recall, firefighters service phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.)				
K161	2000 EXISTING				
	Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4.				
	All existing escalators, dumbwaiters, and moving walks conform to the requirements of ASME/ANSI A17.3, <i>Safety Code for Existing Elevators and Escalators.</i> 19.5.3, 9.4.2.2				

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ID PREFIX		MET	NOT MET	N/A	REMARKS
	(Includes escalator emergency stop buttons and automatic skirt obstruction stop. For power dumbwaiters includes hoistway door locking to keep doors closed except for floor where car is being loaded or unloaded.)				
	2000 NEW	1			
	Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4.				
	All escalators and conveyors comply with ASME/ANSI A17.1, Safety Code for Elevators and Escalators. 18.5.3, 9.4.2.1				
	FURNISHINGS AND DECORATIONS				
K73	Combustible decorations shall be prohibited unless they are flame-retardant or in such limited quantity that hazard of fire development or spread is not present. 18.7.5.4, 19.7.5.4				
< 74	Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations are flame resistant in accordance with NFPA 701 except for shower curtains. Sprinklers in areas where cubical curtains are installed shall be in accordance with NFPA 13 to avoid obstruction of the sprinkler. 10.3.1, 18.3.5.5, 19.3.5.5, 18.7.5.1, 19.7.5.1, NFPA 13				
	□ Newly introduced upholstered furniture shall meet the char length and heat release criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3, 18.7.5.2, 19.7.5.2.				
	□ Newly introduced mattresses shall meet the char length and heat release criteria specified when tested in accordance with the method cited in 10.3.2 (3) and 10.3.4. 18.7.5.3, 19.7.5.3				
	☐ Newly introduced upholstered furniture and mattresses means purchased since March, 2003.	3			
K 75	Soiled linen or trash collection receptacles shall not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space shall not exceed .5 gal/ft² (20.4 L/m²). A	,			
	40 0700D (00/0040)		1		

ID PREFIX		MET	NOT MET	N/A	RE
THEID	capacity of 32 gal (121 L) shall not be exceeded within any 64-ft² (5.9-m²) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) shall be located in a room protected as a hazardous area when not attended. 18.7.5.5, 19.7.5.5		IVIL I		
	LABORATORIES				
K31	Laboratories employing quantities of flammable, combustible, or hazardous materials that are considered a severe hazard shall be protected in accordance with NFPA 99. (Laboratories that are not considered to be severe hazard shall meet the provision of K29.) 18.3.2.2, 19.3.2.2, Chapter 10 (NFPA 99)				
K136	Procedures for laboratory emergencies shall be developed. Such procedures shall include alarm actuation, evacuation, and equipment shutdown procedures, and provisions for control of emergencies that could occur in the laboratory, including specific detailed plans for control operations by an emergency control group within the organization or a public fire department in accordance with 10-2.1.3.1 (NFPA 99), 18.3.2.2., 19.3.2.1				
K131	Emergency procedures shall be established for controlling chemical spills in accordance with 10-2.1.3.2 (NFPA 99)				
K132	Continuing safety education and supervision shall be provided, incidents shall be reviewed monthly, and procedures reviewed annually shall be in accordance with 10-2.1.4.2 (NFPA 99).				
K133	Fume hoods shall be in accordance with 5-4.3, 5-6.2 (NFPA 99).				
K134	Where the eyes or body of any person can be exposed to injurious corrosive materials, suitable fixed facilities for quick drenching or flushing of the eyes and body shall be provided within the work area for immediate emergency use. Fixed eye baths designed and installed to avoid injurious water pressure shall be in accordance with 10-6 (NFPA 99).				
K135	Flammable and combustible liquids shall be used from and stored in approved containers in accordance with NFPA 30, Flammable and Combustible Liquids Code, and NFPA 45, Standard on Fire Protection for Laboratories Using Chemicals.				

ID		MET	NOT	N/A	REMARKS
PREFIX		IVIEI	MET	IN/A	NEWANNS
	Storage cabinets for flammable and combustible liquids shall be constructed in accordance with NFPA 30, Flammable and Combustible liquids Code, 4-3 (NFPA 99), 10-7.2.1 (NFPA 99)				
	MEDICAL GASES AND ANESTHETIZING AREAS				
K76	 Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4 				
K77	Piped in medical gas, vacuum and waste anesthetic gas disposal systems comply with NFPA 99, Chapter 4.				
K78	 Anesthetizing locations shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Shutoff valves are located outside each anesthetizing location and arranged so that shutting off one room or location will not affect others. (b) Relative humidity is maintained equal to or great than 35% 4-3.1.2.3(n) and 5-4.1.1 (NFPA 99), 18.3.2.3, 19.3.2.3 				
K140	 Medical gas warning systems shall be in accordance with NFPA 99, Standard for Health Care Facilities. (a) Master alarm panels are in two separate locations and have audible and visible signals. (b) There are high/low alarms for +/- 20% operating pressure. This section shall be in accordance with NFPA 99, 4-3.1.2.2 (c) Where a level 2 gas system is used, one alarm panel that complies with 4-3.1.2.2(b)3a,b,c,d and with 4-3.1.2.2(c)2,5 shall be permitted. 4-4.1 (NFPA 99) exception No. 4. 4-3.1.2.2 (NFPA 99) 				
K141	Medical gas storage areas shall have a precautionary sign, readable from a distance of 5 ft, that is conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: CAUSION, OXIDIZING GAS(ES) STORED WITHIN, NO SMOKING. 18.3.2.4, 19.3.2.4, 8-3.1.11.3 (NFPA 99)				

	All occupancies containing hyperbaric facilities shall comply with NFPA 99, Standard for Health Care Facilities, Chapter 19.	MET	NOT MET	N/A	REMARKS
	Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows:: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and (b) the area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area that is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and Compressed Gas Association. 8-6.2.5.2 (NFPA 99)				
	ELECTRICAL AND EMERGENCY POWER				
	Hospitals and inpatient hospices with life support equipment have an Type I Essential Electric System, and nursing homes have a Type II ESS that are powered by a generator with a transfer switch and separate power supply in accordance with NFPA 99. 12-3.3.2, 13-3.3.2.1, 16-3.3.2 (NFPA 99)				
	Required alarm and detection systems are provided with an alternative power supply in accordance with NFPA 72. 9.6.1.4, 18.3.4.1, 19.3.4.1				
K108	2000 NEW (INDICATE N/A FOR EXISTING)				
	Power for Alarms, emergency communication systems, and illumination of generator set locations are in accordance with essential electrical system of NFPA 99. 18.5.1.2				
	Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)				
	The Type I EES is divided into the critical branch, life safety branch and the emergency system and Type II EES is divided into the emergency and critical systems in accordance with 3-4.2.2.2, 3-5.2.2 (NFPA 99)				

ID			NOT		
PREFIX		MET	NOT MET	N/A	REMARKS
K146	The nursing home/hospice with no life support equipment shall have an alternate source of power separate and independent from the normal source that will be effective for minimum of 1½ hour after loss of the normal source 3-6. (NFPA 99)				
K147	Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1				
K130	Miscellaneous List in the REMARKS sections, any items that are not listed previously, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.				

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)			JUSTIFICATION	
K84				
Surveyor (Signature)		Title	ffice	Date
Fire Authority Official (Signature)		Title	ffice	Date

FIRE SAFETY SURVEY REPORT CRUCIAL DATA EXTRACT (TO BE USED WITH CMS-2786 FORMS)

PROVIDER NUMBER	FACILITY NAME			,	SURVEY DATE
K1					* K4
к6 DATE OF PLAN APPROVAL	K3 MULTIPLE CONS	BUILDIN	IGS		A BUILDING B WING C FLOOR D APARTMENT UNIT
LSC FORM INDICATOR	<u>i</u>		COMPLETE IF	ICF/MR IS SURVEY	/ED UNDER CHAPTER 21
	are Form 000 EXISTING 000 NEW		K8:	1 PROMPT 2 SLOW 3 IMPRACTICAL	55)
15 2786U 20	000 EXISTING 000 NEW		LARGE	4 PROMPT 5 SLOW 6 IMPRACTICAL	
17 2786V, W, X 20	000 EXISTING 000 NEW DF FORM USED FROM	ABOVE	APARTMENT K8:	HOUSE 7 PROMPT 8 SLOW 9 IMPRACTICAL	
(Check if K29 or K56 are main the 2786 M, R, T, U, V, W			ENTER E – SO	e.g. 2.5	
*K9: FACILITY MEETS LSC E A1. (COMP. WITH ALL PROVISIONS)	A2. (ACCEPTABLE POC)	y) WAIVERS)	A4. [FSES]	A5. (PERFORMANCE BASED DESIGN)	
FACILITY DOES NOT MEET B.			SPRINKLERED areas are sprinklered)	B. PARTIALLY SPRINK (Not all required areas are	

* MANDATORY

Form Approved OMB Exempt

FIRE SAFETY SURVEY REPOR	T 2000 CODE - HEALTH	CARE 1. (A) PR	OVIDER NUMBER 1. (E) MEDICAID I.D. NO.
Medicare -		_{к1} 2453	604 _{K2}	
		ety Code, New and Exer Recommendation F		
Identifying information as shown in applicable	records. Enter changes, if any,	alongside each item,	giving date of change.	
	MULTIPLE CONSTRUCTION (BLDGS			TE, ZIP CODE) A Fully Sprinklered
ANGELS CARE CENTER	A. BUILDING	300 NORTH I CANNON FAI	OOW STREET LLS, MN 55009	B. Partially Sprinklered (Not all required areas are sprinklered (Not all required areas are sprinklered K0180
3. SURVEY FOR 4. DA	ATE OF SURVEY	DATE OF PLAN APPR	OVAL SURVEY UNDER	3
✓ MEDICARE ✓ MEDICAID 1	1/05/2013	К6	5. 2000 EXIS	TING 6 2000 NEW
5. SURVEY FOR CERTIFICATION OF			Titr	
1 OHOSPITAL 2. SKILLED/NURSING	G FACILITY 4. OCF/MR	UNDER HEALTH CARE	5 HOSPICE	
1. OR "5" ABOVE IS MARKED, CHECK APPROPRIATION OF THE PART OF THE		3	a. DES b	SPITAL, IS HOSPITAL ACCREDITED?
6. BED COMPOSITION a. TOTAL NO. OF BEDS b. NUMBER OF HOSP	NTAL PERS			
a. TOTAL NO. OF BEDS IN THE FACILITY 89 b. NUMBER OF HOSP CERTIFIED FOR ME		EDICARE 89 d. NUI	MBER OF SKILLED BEDS TIFIED FOR MEDICAID89	e. NUMBER OF NF or ICF/MR BEDS O CERTIFIED FOR MEDICAID
7. A THE FACILITY MEETS, BASED UPON (CHEC	CK ALL APPROPRIATE BOXES)	*		
1. OCOMPLIANCE WITH ALL PROVISIONS		CORRECTION 3. OEC	OMMENDED WAIVERS 4	FSES 5 PERFORMANCE BASED DESIGN
B. THE FACILITY DOES NOT MEET THE STANI	DARD	•		
SURVEYOR (Signature)	TITLE	OFFICE		DATE
	Deputy State	State Fire	Marchal	14/05/0040
SURVEYOR D 25822	Fire Marshal	Otate i lie	Waishai	11/05/2013
FIRE AUTHORITY OFFICIAL (Signature)	TITLE	OFFICE		DATE
7	Fire Safety Supervisor	State Fire	Marshal	11-19-13

ID REFIX				MET	NOT MET	N/A	REMARKS
	ı	PART I - LSC REQUIREMENTS	- Items in italics relate to the FSES				K11 - 2 hour building separation between Chapel Type V
		BUILDING CO	ONSTRUCTION				building and Nursing home Type II.
K11	the res ad sh lea		gs occur only in corridors and self-closing fire doors with at ing	•	0	0	
<12	Bu	000 EXISTING uilding construction type and h 9.1.6.2, 19.1.6.3, 19.1.6.4, 19.3	eight meets one of the following: 3.5.1				
	1	I (443), I (332), II (222)	Any Height				
	2	II (111)	One story only (non-sprinklered).				
	3	II (111)	Not over three stories with complete automatic sprinkler system.				
	4	III (211)					
	5	V (111)	Not over two stories with complete automatic				
	6	IV (2HH)	sprinkler system.				
	7	II (000)					
	8	III (200)	Not over one story with complete automatic				
	9	V (000)	sprinkler system.				
l	Giv nui are ap	Building contains fire treated vive a brief description, in REMAF umber of stories, including base to located, location of smoke of proval. Complete sketch or at uilding as appropriate.	RKS, of the construction, the ments, floors on which patients rire barriers and dates of				

					NOT		
ID PREFIX				MET	NOT MET	N/A	REMARKS
K12		00 NEW					
		lding construction type and height 1.6.2, 18.1.6.3, 18.3.5.1.	t meets one of the following:				
	10.	1.0.2, 10.1.0.3, 10.3.3.1.					
	1	I (443), I (332), II (222)	Any height with complete automatic sprinkler system				
	2	II (111)	Not over three stories with complete automatic sprinkler system	_			
	3	III (211)					
	4	V (111)	Not over one story with complete automatic				
	5	IV (2HH)	sprinkler system.				
	6	II (000)					
	7	III (200)	Not Permitted				
	8	V (000)	TVOCT CHINICOL				
	☐ Building contains fire treated wood. Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.						
K103	con	erior walls and partitions in building estruction shall be noncombustible terials. 18.1.6.3, 19.1.6.3	gs of Type I or Type II or limited-combustible				
	trea	dicate N/A for existing buildings us ated wood studs within non-load buttions.)	sing listed fire retardant earing one-hour rated				

ID		MET	NOT	N/A	REMARKS
PREFIX	INTERIOR FINIOU	IVILI	MET	IN/A	TILMATIKO
	INTERIOR FINISH				
K14	2000 EXISTING Interior finish for means of egress, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. Interior finishes existing before December 17, 2010 that are applied directly to wall and ceilings with a thickness of less than ½8 inch shall be permitted to remain in use without flame spread rating documentation. 10.2, 19.3.3.1, 19.3.3.2, NFPA TIA 00-2 Indicate flame spread rating/s				
	2000 NEW Interior finish for means of egress, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. Lower half of corridor walls, not exceeding 4ft in height, may have a Class C flame spread rating. 10.2, 18.3.3.1, 18.3.3.2, NFPA TIA 00-2 Indicate flame spread rating/s				
K15	2000 EXISTING Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. (In fully-sprinklered buildings, flame spread rating of Class C may be continued in use within rooms separated in accordance with 19.3.6 from the exit access corridors.) 19.3.3.1, 19.3.3.2 Indicate flame spread rating/s				
	2000 NEW Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. (Rooms not over 4 persons in capacity may have a flame spread rating of Class A, Class B, or Class C). 18.3.3.1, 18.3.3.2. Indicate flame spread rating/s				

ID PREFIX		MET	NOT MET	N/A	REMARKS
(16	2000 EXISTING Newly installed interior floor finish complying with 10.2.7 shall be permitted in corridors and exits if Class I. 19.3.3.3 In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, no interior floor finish requirements shall apply.				
	CORRIDOR WALLS AND DOORS				
K17	Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2, 19.3.6.4, 19.3.6.5 If the walls have a fire resistance rating, give rating if the walls terminate at the underside of a ceiling, give a brief description in REMARKS, of the ceiling, describing the ceiling throughout the floor area.				
	2000 NEW Corridor walls shall form a barrier to limit the transfer of smoke. Such walls shall be permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. No fire resistance rating is required for the corridor walls. 18.3.6.1, 18.3.6.2, 18.3.6.4, 18.3.6.5				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K18	2000 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3		NET		
	Show in REMARKS, details of doors, such as fire protection ratings, automatic closing devices, etc.				
	2000 NEW Doors protecting corridor openings shall be constructed to resist the passage of smoke. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches shall be prohibited. 18.3.6.3				
	Show in REMARKS, details of doors, such as fire protection ratings, automatic closing devices, etc.				
K19	Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) In other than smoke compartments containing patient bedrooms, miscellaneous opening are permitted in vision panels or doors provided the aggregate area of the opening per room does not exceed 20 in.² and the opening is installed in bottom half of the wall (80 in.² in fully sprinklered buildings). 18.3.6.5, 19.3.6.2.3, 19.3.6.3.8, 19.3.6.5				

ID PREFIX		МЕТ	NOT MET	N/A	REMARKS
	VERTICAL OPENINGS				
K20	2000 EXISTING				
	Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5, 8.2.5.6, 19.3.1.1 If all vertical openings are properly enclosed with construction providing at least a two hour fire resistance rating, also check this box.				
	If enclosures are less than required, give a brief description and specific location in REMARKS.				
	2000 NEW				
	Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least two hours connecting four stories or more. (One hour for single story building and buildings up to three stories in height.) An atrium may be used in accordance with 8.2.5.6, 8.2.5, 18.3.1.1.				
	If enclosures are less than required, give a brief description and specific location in REMARKS.				
K21	Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of:				
	 □ (a) The required manual fire alarm system and □ (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and 				
	☐ (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2				
	Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1				
	Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed.				

		1	No.	_
ID PREFIX		MET	NOT MET	N/A
	Describe method used in REMARKS			
	SMOKE COMPARTMENTATION AND CONTROL			
K23	2000 EXISTING			
	Smoke barriers shall be provided to form at least two smoke compartments on every sleeping room floor for more than 30 patients. 19.3.7.1, 19.3.7.2			
	2000 NEW Smoke barriers shall be provided to form at least two smoke compartments on every floor used by inpatients for sleeping or treatment, and on every floor with an occupant load of 50 or more persons, regardless of use. Smoke barriers shall also be provided on floors that are usable, but unoccupied. 18.3.7.1, 18.3.7.2			
K24	The smoke compartments shall not exceed 22,500 square feet and the travel distance to and from any point to reach a door in the required smoke barrier shall not exceed 200 feet. 18.3.7.1, 19.3.7.1			
	Detail in REMARKS zone dimensions including length of zones and dead end corridors.			
K25	2000 EXISTING			
	Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5			
	2000 NEW		 	
	Smoke barriers shall be constructed to provide at least a one hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels in approved frames. 8.3, 18.3.7.3, 18.3.7.5			
K26	Space shall be provided on each side of smoke barriers to adequately accommodate the total number of occupants in adjoining compartments. 18.3.7.4, 19.3.7.4			
	40 0700D (00 (0040)			

ID PREFIX				MET	NOT MET	N/A	REMARKS
K27	2000 EXISTING Doors in smoke barriers rating or are at least 1¾ Non-rated protective plathe bottom of the door a comply with 7.2.1.14. Do closing in accordance wirequired to swing with exprequired. 19.3.7.5, 19.3.	inch thick solid to tes that do not exercised. However, pors shall be self th 19.2.2.2.6. Swaress and positive	oonded core wood. xceed 48 inches from rizontal sliding doors -closing or automatic- vinging doors are not				
	2000 NEW Doors in smoke barriers have rating or are at least 1¾ in rated protective plates that of the door are permitted. 7.2.1.14. Swinging doors in an opposite direction. Devels or astragals are relatching is not required.	nch thick solid bor at do not exceed 4 Horizontal sliding shall be arranged Doors shall be self quired at the mee	nded core wood. Non- 8 inches from the bottom doors comply with so that each door swings -closing and rabbets, ting edges. Positive				
K28	2000 EXISTING Door openings in smoke width of 32 inches (81 cr 19.3.7.7						_
	2000 NEW Door openings in smoke horizontal doors shall pro						
	Provider Type	Swinging Doors	Horizontal Sliding Doors				
	Hospitals and Nursing Facilities	41.5 inches (105 cm)	83 inches (211 cm)				
	Psychiatric Hospitals and Limited Care Facilities	32 inches (81 cm)	64 inches (163 cm)				
	18.3.7.7						

Penetrations of smoke barriers by ducts are protected in accordance with 8.3.5. Dampers are not required in duct penetrations of smoke barriers in fully ducted HVAC systems where a sprinkler system in accordance with 18/19.3.5 is provided for adjacent smoke compartments. 18.3.7.3, 19.3.7.3. Hospitals may apply a 6-year damper testing interval conforming to NFPA 80 & NFPA 105. All other health care facilities must maintain a 4-year damper maintenance interval. 8.3.5 Describe any mechanical smoke control system in REMARKS. HAZARDOUS AREAS 2000 EXISTING One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Area							
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a. Boiler and Fuel-Fired Heater Rooms c. Laundries (greater than 100 sq feet) d. Repair Shops and Paint Shops e. Laboratories (if classified a Severe Hazard - see K31) f. Combustible Storage Rooms/Spaces (over 50 sq feet) g. Trash Collection Rooms i. Soiled Linen Rooms	Aroa	Automatic Sprinkler	Sonaration N/A				
c. Laundries (greater than 100 sq feet) d. Repair Shops and Paint Shops e. Laboratories (if classified a Severe Hazard - see K31) f. Combustible Storage Rooms/Spaces (over 50 sq feet) g. Trash Collection Rooms i. Soiled Linen Rooms		Automatic Sprinkler	Separation IN/A				
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	i. Soiled Linen Rooms						
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	2000 NEW					
	Hazardous areas are protected in accord	ance with 8.4. The				
	areas shall be enclosed with a one hour t	fire-rated barrier, with a				
	3/4 hour fire-rated door, without windows (in accordance with				
	8.4). Doors shall be self-closing or autom					
	accordance with 7.2.1.8. Hazardous area					
	sprinkler system in accordance with 9.7,	18.3.2.1, 18.3.5.1.				
	Area Automa	atic Sprinkler Separation N/A				
	a. Boiler and Fuel-Fired Heater Rooms	and opinines deparation 1471				
	c. Laundries (greater than 100 sq feet)					
	d. Repair, Maintenance and Paint Shops					
	e. Laboratories (if classified a Severe Hazard - see K31)					
	f. Combustible Storage Rooms/Spaces					
	(over 50 and less than 100 sq feet) g. Trash Collection Rooms					
	i. Soiled Linen Rooms					
	m. Combustible Storage Rooms/Spaces (over 100 sq feet)					
	Describe the floor and zone locations of ha	zardous areas that				
	are deficient in REMARKS.					
	are denoient in right into.					
K30	Gift shops shall be protected as hazardou	us areas when used for				
	storage or display of combustibles in qua					
	hazardous. Non-rated walls may separate gift shops that are not					
	considered hazardous, have separate pro					
	are completely sprinkled. Gift shops may					
	if they are not considered hazardous, hav	e separate protected				
	storage, are completely sprinklered and c	lo not exceed 500				
	square feet. 18.3.2.5, 19.3.2.5					
	- equal o 10011 10101210, 10101210					
	Area Automa	tic Sprinkler Separation N/A				
	L. Gift Shop storing hazardous quantities					
	of combustibles					

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K211	Where Alcohol Based Hand Rub (ABHR) dispensers are installed: The corridor is at least 6 feet wide The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) The dispensers shall have a minimum spacing of 4 ft from each other Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. Dispensers are not installed over or adjacent to an ignition source. If the floor is carpeted, the building is fully sprinklered. 18.3.2.7, CFR 403.744, 418.110, 460.72, 482.41, 483.70, 485.623				
	EXITS AND EGRESS				
K22	Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. Doors, passages or stairways that are not a way of exit that are likely to be mistaken for an exit have a sign designating "No Exit". 7.10, 18.2.10.1, 19.2.10.1				
K32	Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Not less than one exit from each floor or fire section shall be a door leading outside, stair, smoke-proof enclosure, ramp, or exit passageway. Only one of these two exits may be a horizontal exit. Egress shall not return through the zone of fire origin. 18.2.4.1, 18.2.4.2, 19.2.4.1, 19.2.4.2				
K33	2000 EXISTING Exit enclosures (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 7.1.3.2, 8.2.5.2, 8.2.5.4, 19.3.1.1				
	If all vertical openings are properly enclosed with construction providing at least a two hour fire resistance rating, also check this box. □				
	If enclosures are less than required, give a brief description and specific location in REMARKS.				
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	2000 NEW				
	Exit enclosures (such as stairways) in buildings four stories or				
	more are enclosed with construction having a fire resistance rating of at least two hours, are arranged to provide a continuous				
	path of escape, and provide a protection against fire and smoke				
	from other parts of the building. In all buildings less than four				
	stories, the enclosure is at least one hour. 7.1.3.2, 8.2.5.2,				
	8.2.5.4, 18.3.1.1, 18.2.2.3				
	If enclosures are less than required, give a brief description and				
	specific location in REMARKS.				
K34	Stairways and smokeproof enclosures used as exits are in				
	accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4				
K35	The capacity of required mean of egress is based on its width, in				
	accordance with 7.3.				
K36	Travel distance (exit access) to exits are measured in				
	accordance with 7.6.				
	• Room door to exit ≤ 100 ft (≤ 150 ft sprinklered)				
	 Point in room or suite to exit ≤ 150 ft (≤ 200 ft sprinklered) Point in room to room door ≤ 50 ft 				
	 Point in room to room door ≤ 50 ft Point in suite to suite door ≤ 100 ft 				
	18.2.6, 19.2.6				
K37	2000 EXISTING				
	Existing dead-end corridors shall be permitted to be continued to				
	be used if it is impractical and unfeasible to alter them so that				
	exists are accessible in not less than two different directions				
	from all points in aisles, passageways, and corridors. 19.2.5.10				
	2000 NEW				
	Every exit and exit access shall be arranged so that no corridor,				
	aisle or passageway has a pocket or dead-end exceeding 30 feet. 18.2.5.10				
1400					
K38	Exit access is so arranged that exits are readily accessible at all times in accordance with 7.1. 18.2.1, 19.2.1				
K39	2000 EXISTING				
1108					
	Width of aisles or corridors (clear and unobstructed) serving as exit access shall be at least 4 feet. 19.2.3.3				
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	2000 NEW				
	Width of aisles or corridors (clear and unobstructed) serving as exit access in hospitals and nursing homes shall be at least 8 feet. In limited care facility and psychiatric hospitals, width of aisles or corridors shall be at least 6 feet. 18.2.3.3, 18.2.3.4				
K40	2000 EXISTING				
	Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 32 inches in clear width. An exception is provided for existing 34-inch doors in existing occupancies. 19.2.3.5				
	2000 NEW				
	Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 41.5 inches in clear width Doors in exit stairway enclosures shall be no less than 32 inches in clear width. In psychiatric hospitals or limited care facilities (e.g.,ICF/MD providing medical treatment) doors are at least 32 inches wide. 18.2.3.5				
K41	All sleeping rooms have a door leading to a corridor providing access to an exit or have a door leading directly to grade. One room may intervene in accordance with 18.2.5.1, 19.2.5.1 If doors lead directly to grade from each room, check this box.				
K42	Any patient sleeping room or suite of rooms of more than 1,000 sq. ft. has at least 2 exit access doors remote from each other. 18.2.5.2, 19.2.5.2				
K43	Patient room doors are arranged such that the patients can open the door from inside without using a key.				
	Special door locking arrangements are permitted in facilities. 18.2.2.2.4, 18.2.2.2.5, 19.2.2.2.4, 19.2.2.2.5				
	If door locking arrangement without delay egress is used indicate in REMARKS 18.2.2.2.2, 19.2.2.2.2				
K44	Horizontal exits, if used, are in accordance with 7.2.4. 18.2.2.5, 19.2.2.5				
K47	Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1, 19.2.10.1				
	(Indicate N/A in one story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)				

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ID PREFIX		MET	NOT MET	N/A
K72	Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1			
	ILLUMINATION			
K45	Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture will not leave the area in darkness. Lighting system shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8, 7.8			
K46	Emergency lighting of at least 1½ hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1.			
K105	2000 NEW (INDICATE N/A FOR EXISTING)			
	Buildings equipped with or requiring the use of life support systems (electro-mechanical or inhalation anesthetics) have illumination of means of egress, emergency lighting equipment, exit, and directional signs supplied by the Life Safety Branch of the electrical system described in NFPA 99. 18.2.9.2., 18.2.10.2 (Indicate N/A if life support equipment is for emergency purposes only).			
	EMERGENCY PLAN AND FIRE DRILLS	1	1	I
K48	There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1, 19.7.1.1			
K50	Fire drills include the transmission of a fire alarm signal and simulation of emergency fire 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. 18.7.1.2, 19.7.1.2			

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PREFIX		MET	NOT MET	N/A	REMARKS
	FIRE ALARM SYSTEMS				
K51	A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6				
K52	A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7,				
K155	Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8				
K53	2000 EXISTING (INDICATE N/A FOR HOSPITAL AND FULLY SPRINKLERED NURSING HOMES) In an existing nursing home, not fully sprinklered, the resident sleeping rooms and public areas (dining rooms, activity rooms, resident meeting rooms, etc) are to be equipped with single station battery-operated smoke detectors. There will be a testing, maintenance and battery replacement program to ensure proper operation. CFR 483.70				
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ID PREFIX		MET	NOT MET	N/A	REMARKS
	2000 NEW (NURSING HOME AND EXISTING LIMITED CARE FACILITIES) An automatic smoke detection system is installed in all corridors. (As an alternative to the corridor smoke detection system on patient sleeping room floors, smoke detectors may be installed in each patient sleeping room and at smoke barrier or horizontal exit doors in the corridor.) Such detectors are electrically interconnected to the fire alarm system. 18.3.4.5.3				
K109	2000 EXISTING LIMITED CARE FACILITIES (INDICATE N/A FOR HOSPITALS OR NURSING HOMES) An automatic smoke detection system is installed in all corridors with detector spacing no further apart than 30 ft on center in accordance with NFPA 72. (As an alternative to the corridor smoke detection system on patient sleeping room floors, smoke detectors may be installed in each patient sleeping room and at smoke barrier or horizontal exit doors in the corridors.) Such detectors are electrically interconnected to the fire alarm system. 19.3.4.5.1 Smoke Detection System □ Corridors □ Rooms				
K54	All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 Give a brief description, in REMARKS of any smoke detection system which may be installed.				
K55	2000 EXISTING Every patient sleeping room shall have an outside window or outside door. Except for newborn nurseries and rooms intended for occupancy for less than 24 hours. 19.3.8 2000 NEW Every patient sleeping room shall have an outside window or outside door. The allowable sill height shall not exceed 36 inches (91 cm) above the floor. Windows are not required for recovery rooms, newborn nurseries, emergency rooms, and similar rooms				

ID		MET	NOT	N/A	REMARKS
PREFIX	intended for occupancy for less than 24 hours. Window sill height for limited care facilities shall not exceed 44 inches (112 cm) above the floor. 18.3.8		MET		
(60	Initiation of the required fire alarm systems shall be by manual fire alarm initiation, automatic detection, or extinguishing system operation. 18.3.4.2, 19.3.4.2, 9.6.2.1				
	AUTOMATIC SPRINKLER SYSTEMS				
(56	2000 EXISTING				
	Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13				
	2000 NEW				
	There is an automatic sprinkler system installed in accordance with NFPA13, Standard for the Installation of Sprinkler Systems, with approved components, device and equipment, to provide complete coverage of all portions of the facility. Systems are equipped with waterflow and tamper switches, which are connected to the fire alarm system. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 18.3.5, 18.3.5.1.				
(154	Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch system be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1.				
	A. Date sprinkler system last checked and necessary maintenance provided				

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	B. Show who provided the service			
	C. Note the source of water supply for the automatic sprinkler system.			
	(Provide, in REMARKS, information on coverage for any non-required or partial automatic sprinkler system.)			
K61	Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72			
K62	Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5			
K63	Required automatic sprinkler systems have an adequate and reliable water supply which provides continuous and automatic pressure. 9.7.1.1, NFPA 13			
K64	Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6			
	SMOKING REGULATIONS			
K66	Smoking regulations shall be adopted and shall include not less than the following provisions: 18.7.4, 19.7.4, 8-6.4.2 (NFPA 99)			
	(1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the internationa symbol for no smoking.			
	Exception: In facilities where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs that prohibit smoking in use areas are not required. (Note: This exception is not applicable to medical gas storage areas.) 8-3.1.11.3 (NFPA 99)			

ID		MET	NOT	N/A	REMARKS
PREFIX	(2) Smoking by patients classified as not responsible shall be prohibited, except when under direct supervision.		MET		
	(3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.				
	(4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.				
	BUILDING SERVICE EQUIPMENT				
K67	Heating, ventilating, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2, NFPA 90A, 18.5.2.2, 19.5.2.2				
<68	Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 18.5.2.2, 19.5.2.2.				
< 69	Cooking facilities shall be protected in accordance with 9.2.3. 18.3.2.6, 19.3.2.6, NFPA 96				
K70	Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C). 18.7.8, 19.7.8				
(71	Rubbish Chutes, Incinerators and Laundry Chutes. 18.5.4, 19.5.4, 9.5, 8.4, NFPA 82				
	(1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1 hour. All new chutes shall comply with 9.5.				
	(2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7.				
	(3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4.				

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PREFIX		MET	NOT MET	N/A	REMARKS
	(4) Existing flue-fed incinerators shall be sealed by fire resistive construction to prevent further use.				
K160	2000 EXISTING				
	Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in A17.1, Safety Code for Elevators and Escalators. Fire Fighter's Service is operated monthly with a written record.				
	Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators & Escalators. All existing elevators, having a travel distance of 25 ft or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. 9.4.2, 9.4.3, 19.5.3				
	(Includes firefighters service phase I key recall and smoke detector automatic recall, firefighters service phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.)				
	2000 NEW				
	Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in A17.1, Safety Code for Elevators and Escalators. Fire Fighter's Service is operated monthly with a written record.				
	New elevators conform to ASME/ANSI A17.1, Safety Code for Elevators and Escalators, including Fire Fighter's Service Requirements. 9.4.2, 9.4.3, 18.5.3				
	(Includes firefighters service phase I key recall and smoke detector automatic recall, firefighters service phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.)				
K161	2000 EXISTING				
	Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4.				
	All existing escalators, dumbwaiters, and moving walks conform to the requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. 19.5.3, 9.4.2.2				
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	(Includes escalator emergency stop buttons and automatic skirt obstruction stop. For power dumbwaiters includes hoistway door locking to keep doors closed except for floor where car is being loaded or unloaded.)				
	2000 NEW	1			
	Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4.				
	All escalators and conveyors comply with ASME/ANSI A17.1, Safety Code for Elevators and Escalators. 18.5.3, 9.4.2.1				
	FURNISHINGS AND DECORATIONS				
K73	Combustible decorations shall be prohibited unless they are flame-retardant or in such limited quantity that hazard of fire development or spread is not present. 18.7.5.4, 19.7.5.4				
< 74	Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations are flame resistant in accordance with NFPA 701 except for shower curtains. Sprinklers in areas where cubical curtains are installed shall be in accordance with NFPA 13 to avoid obstruction of the sprinkler. 10.3.1, 18.3.5.5, 19.3.5.5, 18.7.5.1, 19.7.5.1, NFPA 13				
	□ Newly introduced upholstered furniture shall meet the char length and heat release criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3, 18.7.5.2, 19.7.5.2.				
	□ Newly introduced mattresses shall meet the char length and heat release criteria specified when tested in accordance with the method cited in 10.3.2 (3) and 10.3.4. 18.7.5.3, 19.7.5.3				
	☐ Newly introduced upholstered furniture and mattresses means purchased since March, 2003.	3			
K 75	Soiled linen or trash collection receptacles shall not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space shall not exceed .5 gal/ft² (20.4 L/m²). A	,			
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THEID	capacity of 32 gal (121 L) shall not be exceeded within any 64-ft² (5.9-m²) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) shall be located in a room protected as a hazardous area when not attended. 18.7.5.5, 19.7.5.5		IVIL I		
	LABORATORIES				
K31	Laboratories employing quantities of flammable, combustible, or hazardous materials that are considered a severe hazard shall be protected in accordance with NFPA 99. (Laboratories that are not considered to be severe hazard shall meet the provision of K29.) 18.3.2.2, 19.3.2.2, Chapter 10 (NFPA 99)				
K136	Procedures for laboratory emergencies shall be developed. Such procedures shall include alarm actuation, evacuation, and equipment shutdown procedures, and provisions for control of emergencies that could occur in the laboratory, including specific detailed plans for control operations by an emergency control group within the organization or a public fire department in accordance with 10-2.1.3.1 (NFPA 99), 18.3.2.2., 19.3.2.1				
K131	Emergency procedures shall be established for controlling chemical spills in accordance with 10-2.1.3.2 (NFPA 99)				
K132	Continuing safety education and supervision shall be provided, incidents shall be reviewed monthly, and procedures reviewed annually shall be in accordance with 10-2.1.4.2 (NFPA 99).				
K133	Fume hoods shall be in accordance with 5-4.3, 5-6.2 (NFPA 99).				
K134	Where the eyes or body of any person can be exposed to injurious corrosive materials, suitable fixed facilities for quick drenching or flushing of the eyes and body shall be provided within the work area for immediate emergency use. Fixed eye baths designed and installed to avoid injurious water pressure shall be in accordance with 10-6 (NFPA 99).				
K135	Flammable and combustible liquids shall be used from and stored in approved containers in accordance with NFPA 30, Flammable and Combustible Liquids Code, and NFPA 45, Standard on Fire Protection for Laboratories Using Chemicals.				

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	Storage cabinets for flammable and combustible liquids shall be constructed in accordance with NFPA 30, Flammable and Combustible liquids Code, 4-3 (NFPA 99), 10-7.2.1 (NFPA 99)				
	MEDICAL GASES AND ANESTHETIZING AREAS				
K76	 Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4 				
K77	Piped in medical gas, vacuum and waste anesthetic gas disposal systems comply with NFPA 99, Chapter 4.				
K78	 Anesthetizing locations shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Shutoff valves are located outside each anesthetizing location and arranged so that shutting off one room or location will not affect others. (b) Relative humidity is maintained equal to or great than 35% 4-3.1.2.3(n) and 5-4.1.1 (NFPA 99), 18.3.2.3, 19.3.2.3 				
K140	 Medical gas warning systems shall be in accordance with NFPA 99, Standard for Health Care Facilities. (a) Master alarm panels are in two separate locations and have audible and visible signals. (b) There are high/low alarms for +/- 20% operating pressure. This section shall be in accordance with NFPA 99, 4-3.1.2.2 (c) Where a level 2 gas system is used, one alarm panel that complies with 4-3.1.2.2(b)3a,b,c,d and with 4-3.1.2.2(c)2,5 shall be permitted. 4-4.1 (NFPA 99) exception No. 4. 4-3.1.2.2 (NFPA 99) 				
K141	Medical gas storage areas shall have a precautionary sign, readable from a distance of 5 ft, that is conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: CAUSION, OXIDIZING GAS(ES) STORED WITHIN, NO SMOKING. 18.3.2.4, 19.3.2.4, 8-3.1.11.3 (NFPA 99)				

	All occupancies containing hyperbaric facilities shall comply with NFPA 99, Standard for Health Care Facilities, Chapter 19.	MET	NOT MET	N/A	REMARKS
1440					
	Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows:: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and (b) the area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area that is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and Compressed Gas Association. 8-6.2.5.2 (NFPA 99)				
	ELECTRICAL AND EMERGENCY POWER				
	Hospitals and inpatient hospices with life support equipment have an Type I Essential Electric System, and nursing homes have a Type II ESS that are powered by a generator with a transfer switch and separate power supply in accordance with NFPA 99. 12-3.3.2, 13-3.3.2.1, 16-3.3.2 (NFPA 99)				
	Required alarm and detection systems are provided with an alternative power supply in accordance with NFPA 72. 9.6.1.4, 18.3.4.1, 19.3.4.1				
K108	2000 NEW (INDICATE N/A FOR EXISTING)				
	Power for Alarms, emergency communication systems, and illumination of generator set locations are in accordance with essential electrical system of NFPA 99. 18.5.1.2				
	Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)				
	The Type I EES is divided into the critical branch, life safety branch and the emergency system and Type II EES is divided into the emergency and critical systems in accordance with 3-4.2.2.2, 3-5.2.2 (NFPA 99)				

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K146	The nursing home/hospice with no life support equipment shall have an alternate source of power separate and independent from the normal source that will be effective for minimum of 1½ hour after loss of the normal source 3-6. (NFPA 99)				
K147	Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1				
K130	Miscellaneous List in the REMARKS sections, any items that are not listed previously, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.				

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

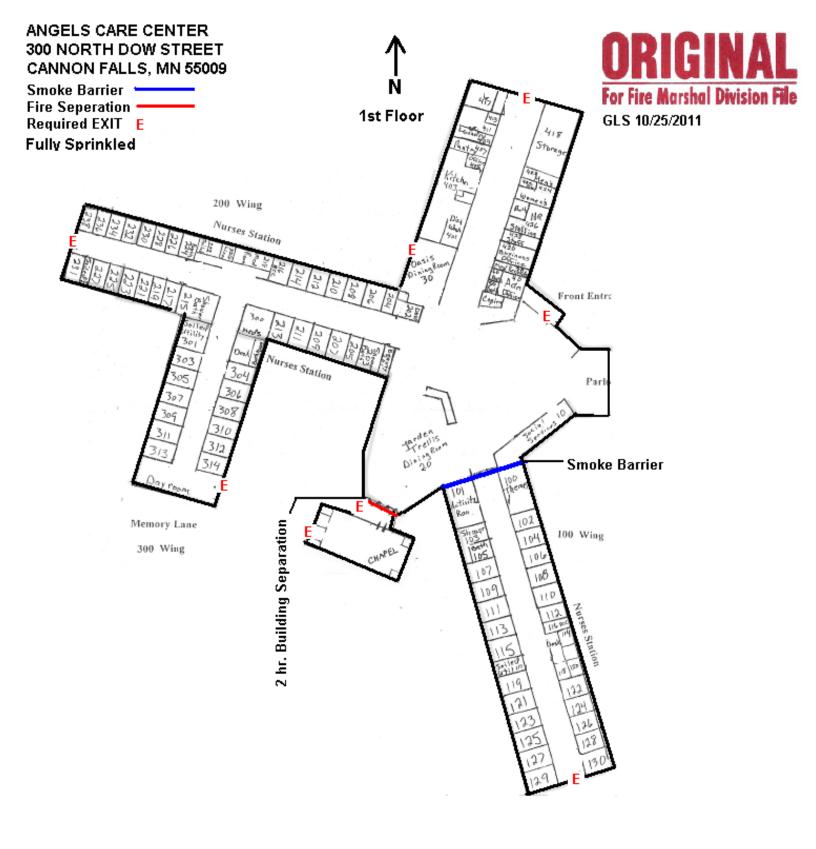
PROVISION NUMBER(S)			JUSTIFICATION	
K84				
Surveyor (Signature)		Title	ffice	Date
Fire Authority Official (Signature)		Title	ffice	Date

FIRE SAFETY SURVEY REPORT CRUCIAL DATA EXTRACT (TO BE USED WITH CMS-2786 FORMS)

PROVIDER NUMBER	FACILITY NAME			,	SURVEY DATE						
K1					* K4						
K6 DATE OF PLAN APPROVAL	K3 MULTIPLE CONST TOTAL NUMBER OF E NUMBER OF THIS BU	BUILDIN	IGS	A BUILDING B WING C FLOOR D APARTMENT UNIT							
LSC FORM INDICATOR	<u>i</u>		COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 2 SMALL (16 BEDS OR LESS)								
	are Form 000 EXISTING 000 NEW		K8:	1 PROMPT 2 SLOW 3 IMPRACTICAL	55)						
15 2786U 20	000 EXISTING 000 NEW		LARGE	4 PROMPT 5 SLOW 6 IMPRACTICAL							
17 2786V, W, X 20	000 EXISTING 000 NEW DF FORM USED FROM A	ABOVE	APARTMENT K8:	HOUSE 7 PROMPT 8 SLOW 9 IMPRACTICAL							
(Check if K29 or K56 are main the 2786 M, R, T, U, V, W	• •		ENTER E – SO	e.g. 2.5							
*K9: FACILITY MEETS LSC E A1. (COMP. WITH ALL PROVISIONS)	A2. (ACCEPTABLE POC)	A3.	y) WAIVERS)	A4. [FSES]	A5. (PERFORMANCE BASED DESIGN)						
FACILITY DOES NOT MEET B.	F		SPRINKLERED areas are sprinklered)	B. PARTIALLY SPRINK (Not all required areas are							

* MANDATORY

Ainnesota 4 6 1	State Fire Marsh	nal Division-CMS Survey Draft Statemen	t of Deficiencies		Page of
PROJEC	T NUMBER:	PROVIDER NAME			SURVEY DATE
Adminis	strator:		Phone Numl	per:	
Email a	ddress:				W
State Fir	re Inspector:	2			** *** *******************************
	re preliminary f	findings only. A complete and final S	tatement of Deficiencies	2567 report v	vill be provided
Sa	fety Code appl	s inspection. this facility was found to licable to: SNF/NF Hospital Medicaid programs.			
☐ Th	e following fir	re/life safety deficiencies were fou	nd during this inspect	ion:	
K TAG S& S	☐ Draft	Summary of Deficiency(ies)	☐ Revisit	☐ Clea	rance
			0.00.000		



CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: ETLH

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

PAI	RT I - TO BE COMPL	ETED BY TH	IE STAT	E SURVE	YAGI	ENCY		Fa	cility ID: 00758	
MEDICARE/MEDICAID PROVIDER NO. (L1) 245304 2.STATE VENDOR OR MEDICAID NO. (L2) 908108900	3. NAME AND ADDRE (L3) ANGELS (L4) 300 NORT (L5) CANNON	CARE CENTH DOW ST	NTER FREET	[(L6)	5500	1. Init 3. Ter 5. Val	mination idation	2 (L8) 2. Recertification 4. CHOW 6. Complaint	on
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SUPPLI	IER CATEGORY	09 ESRD	<u>02</u> 13 PTIP	(L7)	22 CLIA		-Site Visit I Survey After Com	9. Other	
6. DATE OF SURVEY 11/08/2013 (L34) 8. ACCREDITATION STATUS: (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other	03 SNF/NF/Distinct	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORE 15 ASC 16 HOSP			FISCALY	YEAR ENDING E	DATE: (I	235)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 89 (L18) 13. Total Certified Beds 89 (L17) 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF 89 (L37) (L38) (L39) 16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE)	ICF (L42)	With rements sed On: ptable POC nce with Program and/or Applied Wa IID (L43)	aivers:	2 3 4 4 5 4 Code:	2. Techn 3. 24 Hd 4. 7-Day 5. Life S	our RN / RN (Rural SN Safety Code	F)	equirements: Scope of Service Medical Directo Patient Room Siz Beds/Room (L15)	r	
See Attached Remarks										
17. SURVEYOR SIGNATURE	Date :			18. STATI	E SURV	EY AGENCY A	APPROVAL		Date:	
Gail Sorenson, HFE NE II	01	/14/2014	(L19)	<u>Kate JohnsTon, Enforcement Specialist</u> 02/26/14						5/14 (L20)
PART II - TO	O BE COMPLETED E	BY HCFA REC	GIONAL	OFFICE	OR SI	INGLE STA	TE AGENC	CY		
DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participate 2. Facility is not Eligible (L21)	20. COMPLI RIGHTS	IANCE WITH CIV ACT:	VIL	21.	2. O			HCFA-2572) sure Stmt (HCFA-	1513)	
22. ORIGINAL DATE 23. LTC AGREE OF PARTICIPATION BEGINNIN 02/01/1986 (L24) (L41) 25. LTC EXTENSION DATE: 27. ALTERNATI		LTC AGREEMEN ENDING DATE (L25)	VT	VOLUNTA 01-Merger 02-Dissatis	ARY , Closure sfaction	_		(L: INVOLUNTA 05-Fail to Mee 06-Fail to Mee	kRY et Health/Safety	
A. Suspensio	on of Admissions: uspension Date:	(L44) (L45)		04-Other R	teason fo	or Withdrawal		07-Provider S 00-Active	tatus Change	
28. TERMINATION DATE:	29. INTERMEDIARY/CARI	RIER NO.		30. REMA	ARKS					
(L28)	03001		(L31)							
31. RO RECEIPT OF CMS-1539	32. DETERMINATION OF A	APPROVAL DATE	3							
(L32)			(L33)	DETER	MINA	ΓΙΟΝ APPR	OVAL			

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00758

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN-245304

At the time of the standard survey completed November 8, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F). In addition, at the time of the November 8, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number H5304018 that was found to be substantiated findings at F241, F312, F353. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow. Refer to the CMS 2567 for health and life safety code along with the facility's plan of correction.



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 6657

December 11, 2013

Ms. Kristina Umberger, Administrator Angels Care Center 300 North Dow Street Cannon Falls, Minnesota 55009

RE: Project Number S5304023, H5304018

Der Ms. Umberger:

On November 8, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the November 8, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number H5304018.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the November 8, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number H5304018 that was found to be substantiated findings at F241, F312, F353.

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

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

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

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

Angels Care Center December 11, 2013 Page 2

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

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - 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:

Gary Nederhoff, Unit Supervisor Minnesota Department of Health 18 Wood Lake Drive Southeast Rochester, Minnesota 55904-5506

Telephone: (507) 206-2731 Fax: (507) 206-2711

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 December 18, 2013, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by December 18, 2013 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

Angels Care Center December 11, 2013 Page 3

PLAN OF CORRECTION (PoC)

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of

Angels Care Center December 11, 2013 Page 4

Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by February 8, 2014 (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

Angels Care Center December 11, 2013 Page 5

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 May 8, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division 444 Cedar Street, Suite 145 St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Angels Care Center December 11, 2013 Page 6

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring P.O. Box 64900 St. Paul, Minnesota 55164-0900

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

Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File

5304s14.rtf

PRINTED: 12/11/2013 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		245304	B. WING _	DEC 24 2013	11/08/2013
	PROVIDER OR SUPPLIER CARE CENTER			STREET ADDRESS CITY STATE, ZIP CODE 300 NORTH DOWSTREET CANNON FALLS, MN 55009	``
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 000	INITIAL COMMEN	TS	F 00	00	
	as your allegation of Department's accellent bottom of the first pube used as verificated. Upon receipt of an revisit of your facilit validate that substated regulations has been your verification.	acceptable POC an on-site y may be conducted to intial compliance with the an attained in accordance with			
F 241 SS=E	at the time of the st Investigation/s of co completed and had Deficiency/s had be substantiated finding	gation/s had been completed andard recertification survey. It is a part of the part of the gs at F241, F312, F353. AND RESPECT OF	F 24	F Tag 241 Dignity	
	manner and in an e	omote care for residents in a nvironment that maintains or ident's dignity and respect in s or her individuality.	Accept		tions th iewed
	by: Based on observate review, the facility faci	ion, interview, and document ailed to promote a dignified the secured unit (Memory sidents (R66, R63, R65, R38, R56) observed during a meal. 66 was not assisted to eat set the table ate	Danfus on 12/2, GPN/GI	for staff to accept at the last	th ent f etures ues, ing as

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the safeguards provide sufficient protection to the patients. See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ollowing 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 lays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

per email 12-24-13
per telephone 12-31-13
rsions Obsolete MY Event IE rogram participation.

DEC 214 2013

PRINTED: 12/11/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION . MN Dept of Health

(X3) DATE SURVEY COMPLETED

245304

B. WING

11/08/2013

NAME OF PROVIDER OR SUPPLIER

ANGELS CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009

ANGELS	ANGELS CARE CENTER			CANNON FALLS, MN 55009			
			C	ANNON FALLS, MIN 55009		_	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
				and updated to include interventions			
F-241		F 2	241	for staff to provide cues, prompts,	-		
	independently and when assisted to eat the food	•		redirection and assistance as needed		-	
	was not checked for warmth as it sat in the food			at mealtime. R38's careplan was			
	cart and in front of R66 for a total of 37 minutes.			reviewed and updated to include			
	R66 was admitted 6/24/2011 with a diagnosis of		.	interventions for staff to assist at			
	dementia, hallucinations, dementia with			mealtime with cues, prompts and			
	behavioral disturbance, esophageal reflux, legal			assistance as needed. R73's careplan			
	blindness, panic disorder and depressive			was reviewed and updated to include			
	disorder			interventions for staff to prepare			
	A Quarterly Minimum Data Set assessment dated			resident for meals and provide			
	8/12/2013 identified R66 as severely cognitively			redirection, prompts, cues and		ı	
	impaired and required extensive assist of one for		}	assistance as needed. R82's careplan			
	eating.		1	was reviewed and updated to include			
	On 11/4/2013 12:12 p.m., the food cart arrived in			prompts for staff to redirect and			
	the unit from kitchen. At 12:35 p.m., R66 received			provide assistance as needed at		Ţ.	
	their food tray which had been uncovered. There			mealtime. R56's careplan was		Ļ	
	were three other residents at this table and all			reviewed and updated to include		1	
	three began to eat as soon as the meal was		}	interventions for staff to redirect and		ı	
	provided. R66 just watched the others eat until			provide cues and assistance as needed			
	R66 picked up a plastic covered piece of bread and started chewing on it as the nurse had not			at mealtime.			
	removed the plastic from the sandwich when			In addition, the following			
	meal was set before R66. After the nurse had			interventions will be implemented on			
	removed the plastic from the sandwich R66 make			the 300 wing. 1. Meal trays will be			
	no attempt to eat independently. At 12:42 p.m.,			placed in the food cart according to			
	nurse manger (NM)-A sat next to R66 and began to assist R66 to eat. However, the food that had			seating, not by diet. 2. A current			
	been delivered thirty minutes ago and sat		l	seating chart will be maintained by		İ	
	uncovered for seven minutes was not warmed for			the Nurse Manager for all meals. 3.			
	the resident.			The Nurse Manager or Charge Nurse			
				for the unit will be responsible for			
	On 11/6/2013, food trays arrived at 11:55 a.m. in			calling for additional assistance at			
	the unit, R66 again received a tray uncovered at			meal time if needed. 4. All staff will			
	12:15 p.m. and made no attempt to eat and soon fell asleep in the wheelchair. No staff encouraged or assisted R66 to eat until nursing			be re-educated on the correct			
•			ļ	procedures to be used during meal			
	assistant (NA)-F sat next to R66 at 12:43 p.m.			service, including: completing one		I	

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

PRINTED: 12/11/2013 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMP	LETED
	·		DEC 2 4 2013	:	ار
	245304	B. WING		11/0	8/2013 🧷
NAME OF PROVIDER OR SUPPLIER ANGELS CARE CENTER	,	3	STREET ADDRESS, CITY STATE, ZIP CODE 00 NORTH DOW STREET CANNON FALLS, MN 55009		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
minutes and had be minutes prior to bein questioning NA-F at being cool NA-F sai still warm and made for temperature or warm at the time the form the kitch the form the kitch that the time the time the took the milk and stand grabbed the calmo staff cueing to en when it was set in from the time took the foods to warm at the time R6 During the entire me	en the table uncovered for 28 en in the food cart for 20 ng set in front of R66. On 12:43 in regards to the food d that she felt the food was no attempt to test the food warm the food for R66. The eat, not to eat cake with a fork and foods were not as after setting for 38 minutes of was delivered to the unit and to eat the food. With diagnoses this included enile dementia. The defended and and cueing after set up of and cueing after set up of the food was observed to be the food was placed in awoke at 12:33 p.m. R63 arted drinking some after this are of cake unto the plate with her fingers. There was courage R63 to eat the meal ont of her or to use a fork to be gan to eat the foods. all service for R63 there was seated at the same table.	F 241	table before starting another, crea a calm, quiet environment, washin hands before and after meals, kee plates covered, and offering assistance to residents as needed. A management staff person will be assigned to the 300 wing at meal t to monitor and assist as needed. The DON, Nurse Managers and the Dietary Manager will implement measures to ensure that all reside in all dining rooms will be assisted needed, and that the dining experience is pleasant and dignifie See interventions noted above and below. The procedure for meal assistance all dining rooms will be reviewed a updated and staff will be educated the revised procedures, with an emphasis on the problems noted during the survey: Residents will be offered washcloths for cleansing before and after meals; Residents table will all be served before start the next table; Staff will intervene there are disruptions during the m Residents will be offered cueing, prompting and assistance as need steps will be taken to ensure food served at the correct temperature	ping 5. e ime nts as d in and d on pe at a ling if heal; is	

PRINTED: 12/11/2013 FORM APPROVED · OMB NO. 0938-0391

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD			Í		E SURVEY PLETED
	. •	245304	B. WING		DEC 2 4 2013		11/0	08/2013
	PROVIDER OR SUPPLIER CARE CENTER			30	TREET ADDRESS, CIT CONTROL OF CODE 00 NORTH DOW STREET ANNON FALLS, MN 55009	-		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD I	BE IATE	(X5) COMPLETION DATE
F 241	denture during mean encourage her to do her hand while attersame hand. R65 had diagnoses dementia, altered modisorder. R65's annual MDS identified R65 as seand required superfor eating. On 11/6/2013 at 11: to the dining area of was Tater tot Hotdischocolate chip dessareceived a food tray resident used a forkleft hand. The resident used a forkleft hand the resident used it back in the was done eating the cake she just placed it back in the was done eating and dentures which she During the entire mean dentures which she the meal nor had the fork to eat the foods	erved to not wear lower all and no staff attempted to o so. R65 held the denture in impting to use fork with the which included: senile mental status and depressive assessment dated 10/11/2013 everely cognitively impaired vision and cueing of one staff 55 a.m., the food cart arrived f memory lane. The menusch and rutabagas and sert. At 12:01 p.m. R65 of regular textured food. The stand started to eat with the dent was observed to be redentures in the left hand rk to eat. At 12:12 p.m., the cake using her fingers. At the her fingers to remove some put into her mouth and the bowl. At 12:27 p.m., R65 d was still holding the bottom had during the entire meal. The provided with coughing while eating the entire to eat expressions.	F 2	241	The Director of Nursing, Nurse Managers and the Dietary Marwill monitor the effectiveness of the actions, including: Conduct random meal observations, including: The Birector of Nursing, Nurse Managers and the Dietary Marwill monitor the corrective actions, including: Conduct random meal observations, including: Conduct random meal observations, including: The 300 wing Nurse Manager was a seen of the evening meal in all dining rooms from the evening meal in all dining room will provide re-education as near and report issues to the DON and Administrator. Upon completion of reviews/acorrective actions, if applicable corrective actions actio	ceductice I on duca nage ions ese ation or 3 will keepend/oudits end/oudits e	res ,	
		0 a.m., a licensed practical interviewed regarding R65 's			completed immediately. Addi education will be provided as		I	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		E CONSTRUCTION	CO	TE SURVEÝ MPLETED	
		245304	B. WING		DEC 2 4 2013	11	· /08/2013	;;;
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE ZIP CODE	1 11/	10012013 1	
	CARE CENTER			3	00 NORTH DOW STREET CANNON FALLS, MN 55009			
	SLIMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	N.	(X5)	
, (X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	COMPLETION DATE	
					from the reviews. Failure to adhe	re_to		_
F 241	Continued From pa		F:	241	educated protocols will result in	!		
		m dentures while eating the noon. LPN-D indicated R65			corrective counseling.	. ;		
	would take denture	s out of mouth and put them in	•		The results of monitoring of the	•	.]	
	t .	wanted. LPN-D said that staff			corrective actions (track, trend ar	ıd		
		5 to wear dentures while			analysis) will be reported to the			
		bserved at 8:30 to be eating re in her left hand. After			facility QA Committee monthly fo	r 6		
		f R65 holding onto denture			months. Upon this review, syster	n		
		l R65 and asked her put her			revisions and/or staff education v			
		r mouth. R65 nodded yes and			be implemented if indicated via a			
		ture in R65 's mouth and R65			prescribed corrective action plan	•		
	made no attempt to rest of the meal.	remove the denture for the			•			
		ed during dining in a timely			Audits will be reduced based on		1	
	manner.	is a justified anning in a timely			compliance and recommendation	าร		
	A quarterly minimu	m data set assessment dated d resident as severely			from the QA Committee.		17	
		d and required limited assist of			Facility DON and E.D. will be		il.	
		. The resident had diagnoses			responsible for maintaining			
		heimer's dementia, aphasia,			compliance.		1	
	and depression.	1140 m ma the feed contamined						
	on memory lane un	::12 p.m., the food cart arrived			The facility alleges that it will be i	n		
		B was given a tray of food			substantial compliance with the		- 1	
		resident started playing with			standard indicated by 12/18/13.		12-18-1	_
		The resident made no attempt					1	-
		assisted the resident. At 12:42			·			•
		ger (NM)-A sat down by R38						
		sident to eat. The resident 's did cart for 13 minutes and then						
	1	other 17 minutes before the		•				
		assisted to start to eat.						
	, ,	e resident continued to play						
	l .	ood. Other residents at the						
	table were eating.	·						
	D27 was not sons	stantly ayad nor assisted to set						
		stently cued nor assisted to eat er food plate had been put in						
		ff sat to assist her to eat. Also						

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	T OF DEFICIENCIES OF CORRECTION .	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD			COM	E SURVEY IPLETED	
ng e		245304	B. WING	·	DEC 2 4 20	11/	08/2013 <i>(</i>	
	PROVIDER OR SUPPLIER CARE CENTER		•	3	STREET ADDRESS, CITY, STATE, QUE CODE Rochester CANNON FALLS, MN 55009	<i>'</i> 3		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	DBE .	(X5) COMPLETION DATE	
==F-241	A quarterly MDS daresident as modera required supervision eating. Diagnoses depression, demeror on 11/6/2013 at 11 in the memory lane of food uncovered observed to be asked food arrived. NA-C couple of times, but as soon as NA-C lenext to R37 and be was 33 minutes aft unit and 21 minutes uncovered in front the food for temper to warm the foods. R73 was not assist dining. On 11/4/2013 at 12 on the memory lanext 12:42 p.m., R73 of her and it was unin the food cart for been checked for the R73.	een checked for temperature in assisting her to eat. ated 9/5/2013 identified the ately cognitively impaired and on and cueing of one staff for included: malnutrition,		241				
	wheelchair with lap	buddy on wheeling self oom as other residents were						

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OLIVILI	TO I OIL MEDIOMILE	WINDOWN CENTRAL					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ECONSTRUCTION DEC 24 2013	(X3) DATE COMP	SURVEY
		245304	B. WING		MN Dept of Health	11/0	8/2013
	PROVIDER OR SUPPLIER CARE CENTER			30	TREET ADDRESS, CITY, STATE, ZIP CODE NO NORTH DOW STREET ANNON FALLS, MN 55009	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241	singing loudly and f she was assisted to eat her meal at 12/4 was yelling at R73 t R56 would add to the Hello! " then R56 to loudly on the table. interventions for an from residents mak disruptive dining ex residents living on the the privacy of their at the start of the massisted	be assisted to eat. R73 was or long periods of time until o a table and encouraged to 42 p.m. During this time R82 to "Shut up! Shut up!" Then ne yelling by saying, "Hello! used her spoon to pound it There were no staff y of these disruptive behaviors ing an unpleasant and perience for 16 of the 17 he unit as one resident at in bedroom. It was also observed leal that no resident had their in though several had used	F 2	241			
F 280 SS=D	11/7/2013 at 9:00 a regarding dining ob LPN-D stated it had residents to wait to staffing. LPN-D sa nursing assistant at shift for 17 resident assistance. The resistance is not always reheating time waiting to said that the staff we residents as they simeal or to be able to during dining becautining meal to just 483.20(d)(3), 483.1 PARTICIPATE PLA	A5 p.m. and again on .m., LPN-D was interviewed servations on 11/4/13 at noon. If been normal for some of the eat because of the short id that they usually staffed one and one nurse during the day as who needed quite a bit of sidents are assisted to eat as et around to them and the food ted for the residents who sat a be assisted to eat. LPN-D wasn't always able to cue the hould have been to eat their to monitor behaviors closely use it was too busy during the get residents assisted to eat. O(k)(2) RIGHT TO NNING CARE-REVISE CP	F2	280	F Tag 280 The IDT reviewed resident # R56 plan and documentation related recent falls and made revisions to care plan and care assignment so Revision included an intervention remind the resident's husband retransfer resident for safety reason Nurse Manager reviewed care potherometrics.	to to the heet. n to tot to ons.	

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245304	B. WING		DEC 2 4 2013	4411	1	
NAME OF	PROVIDER OR SUPPLIER	240004	2, ,,,,,,		TREET ADDRESS, CITY, STATE ZIP CODE	1 11/0	08/2013 \(\square\)	
ANGELS	CARE CENTER				00 NORTH DOW STREET CANNON FALLS, MN 55009			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		BE	(X5) COMPLETION DATE	
					The Director of Nursing and Nur	se		
F-280	Continued From pa		F 2	280	Managers will implement correc	tive		
	incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or				actions for other residents poter	ntially		
					affected by this practice includin	ıg:		
	changes in care and				identification via comprehensive	:		
	A				record review specific to falls. A	11		
	A comprehensive care plan must be developed within 7 days after the completion of the				residents will be reviewed at car	e		
		essment; prepared by an			conference and/or with significa	nt		
	interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in				changes, including increased fall	s. i		
						i		
		nined by the resident's needs,			The Director of Nursing or design	: 1		
	and, to the extent pr	acticable, the participation of	•		will implement measures to ensu			
		ident's family or the resident's		İ	that this practice does not recur,			
		; and periodically reviewed am of qualified persons after			including: Re-education of nursi	_		
	each assessment.	an or quanted persons after]	staff on the policies and procedu	4	4
		·			related to falls. Nursing staff wa	S	\\	
	•	•			educated on 11/27/13.			
	This REQUIREMEN	T is not met as evidenced			A review of the revised policies a	nd :		
	by:	is not met as evidenced		Ì	procedures by the Medical Direct	tor		
	Based on observati	on, interview and document			will be conducted to determine i	f		
		illed to update the care plan			policies meet current standards of	of		
		I to falls for 1 of 3 residents alls and failed to develop care			practice.	ŀ		
•	•	address non-English			·			
	speaking communic	ation needs for 1 of 1			The Director of Nursing and /or			
	resident (R78) who	only understood Spanish.		1	designee will monitor the correct	ive:		
	Findings include: R	56 had frequent falls and the			actions to ensure the effectivene	ss of		
	facility had assessed	d that family (F)-A had been		- 1	these actions, including: Weekly			
		the falls had occurred.			audits of 3 resident charts that ha	ave		
		ention to remind F-A to seek ded to be transferred had not			had falls.	.		
		care plan for staff to be						
	aware of this concer				The IDT reviewed resident # R78'	s care		
				_	plan and documentation related	to		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	NG	OMPLETED
	•	245304	B. WING _	DEC 2 4 2013	11/08/2013
	PROVIDER OR SUPPLIER	2		STREET ADDRESS, CITY, STATE THE STATE OF THE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLETION DATE .
	0-4		F 20	communication and made revisions	to
F 280	observed to push visit. R56 had diagnose history of rib fractivertebra fractures Incident in notes of found on floor on Predisposing factor impaired memory Incident in notes on floor next to the hip pain, but had motion. The quarterly Min indicated R56 was and required extered bed mobility and of Assessment dates moderate risk for poor decision mal history of pain with and a history of a R56 's care plan impaired mobility dementia, hypertes elf-transfers as edecreased safety mobility. The care	a.m. R56's F-A had been R56 in the wheelchair while sthat included dementia, are, femur fractures, and lated 9/25/13 read that R56 was knees holding the bed. Ors included gait imbalance and No injury was noted. Itated 10/13/13 R56 was found to bed. R56 complained of right no difficulty with range of severally cognitively impaired insive assistance with transfers, Italian related to cognitive deficits, sing, urinary incontinence, and weight bearing, medications, gitated behaviors. Sundated identified a problem of with risk for falls related to ension, osteoarthritis, evidenced by a history of falls, awareness, need assist with plan lacked an intervention or	F 28	the care plan and care assignment sheet. Revision included adding use communication cards to residents or plan. Interpreter services will be offered Social Service will implement corrective actions for other resident potentially affected by identifying other residents with possible langu barrier. All residents will be review at admission for language barrier. Interpreter services or communications will be arranged and care planned as appropriate. Social Services will ask prior to admission if new residents have an language barrier and proper communication services will be arranged. Social Services will audit residents once a month for 6 months to ensuproper communication is being offered.	e of care ts age ved tion
	reminding the spot transfer. Nursing Assistant 11/8/13 at 9:49 a.	(NA)-B was interviewed on m. NA-B stated she thought		Upon completion of reviews/audits corrective actions, if applicable will completed immediately. Additional education will be provided as derive from the reviews. Failure to adher	l be al ved

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		L CON		E SURVEY IPLETED
		245304	B. WING		DEC 2 4 2012	11/	08/2013
	PROVIDER OR SUPPLIER	₹		30	TREET ADDRESS, CITY NO TATE, ZIP CODE 100 NORTH DOW STREET COLORISM CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 280	happen. NA-B statempt to transfer attempt to transfer Clinical Manager (11:00 a.m. on 11/8 been falling a lot, I transferring R56 a falling. CM-B statemuch as possible not to help transfer this occurs. During an interview director of nursing not include an interview of the companion of the com	ies to intervene if they see this ated she has never seen R56 r self. (CM)-B was interviewed at 8/13. CM-B stated R56 had but now that F-A had not been alone as much, R56 was not led F-A liked to help C56 as and needed reminders by staff r R56 alone as R56 falls when w on 11/8/13 at 12:20 p.m. the verified R56 's care plan did ervention related to reminding R56 and get help if R56 needs	F2	280	educated protocols will result is corrective counseling. The results of monitoring of the corrective actions (track, trend analysis) will be reported to the QA Committee monthly for 6 m. Upon this review, system revisionand/or staff education will be implemented if indicated via a prescribed corrective action pland Audits will be reduced based of and recommendations from the Committee. Facility DON and E.D. will be responsible for maintaining compliance.	e and e facility nonths. ions an.	
	diagnoses that incomprain damage, apl Minimal Data Set preferred language rarely/never under assessment (CAA identified nature of essentially non-vedamage, aphasia, characteristics of the R78's care plan revulnerable adult as and is unable to comprain the properties of the set of the s	mitted on 6/4/13. R78 had sluded but not limited to anoxic hasia. R78's significant change (MDS) dated 10/15/13 identified a Spanish, no speech, stood. R78's care area) worksheet dated 10/21/13, if the problem/condition: rbal related to anoxic brain primary language Spanish and the communication impairment.			The facility alleges that it will be substantial compliance with the standard indicated by 12/18/1	ie .	12-18-13

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		E CONSTRUCTION		MPLETED
		245304	B. WING	;	DFC 24 acc	11.	/08/2013
	PROVIDER OR SUPPLIER CARE CENTER			30	TREET ADDRESS, CITY, STATE, ZHO ON NORTH DOW STREET OF HEALTH ANNON FALLS, MN 55009	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
					•		
F 280	had no other interv communication nee R78's therapeutic r	entions to promote	F :	280	•		
	During observation activities-A had bee in English and had not speak English, talk. She had state Spanish. The televi	on 11/4/13, at 1:09 p.m., en in R78's room talking to R78 stated to surveyor R78 does R78 looks at you but does not d R78's language was sion had been on in R78's n on the Spanish channel for	-			·	
	service person state English, is non-verlenot worked with R7 and communication	a 11/7/13, at 8:44 a.m., social ed R78 does not speak oal and speech therapy had 8 regarding language barrier a. Social service stated she terpreter with family, not sure lo.					
	nursing assistant (I Spanish. NA-E sta use hand gestures. development gave English words conv	11/7/13, at 12:55 p.m., NA)-E stated I do not speak ted I talk to R78 in English and NA-E stated staff a sheet with some simple verted to Spanish for us to use not used routinely and not part					
	therapist stated she only for R78. Speed tried some communicand there was no re- verified there is no	a 11/7/13, at 2:00 p.m., speech e provided swallow therapy ch therapist stated she had nication in Spanish with R78 esponse. Speech therapist documentation in therapy				· .	

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		TE SURVEY MPLETED	
•	•	245304	B. WING _	DEC 2 4 2013	11/	08/2013	
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE ZIP CODE	1 17	00/2013	
ANGELS	S CARE CENTER			300 NORTH DOW STREET CANNON FALLS, MN 55009			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)) BE	(X5) COMPLETION DATE	
F 280	Continued From pa	ge_11	F-28	0.	1000 2000	·	
	given anything to st	aff to use for communication. rified R78 understands and	, 20				
	director of nursing v speaks Spanish only she would expect in communicate and in Director of nursing s	volve family to communicate. stated she would expect					
F 282 SS=D	communication to be 483.20(k)(3)(ii) SER PERSONS/PER CA	VICES BY QUALIFIED	F 282	statement of deficiency has bee	en		
	must be provided by	ed or arranged by the facility qualified persons in ch resident's written plan of	·	reassessed for ability to feed se Corresponding updates have be made to the care plan, care assignment sheet and communito the resident and/or designate	cated	. (
	by: Based on observation review, the facility fa	sed and care planned for 1 of		decision maker. All staff responder for care for the resident has been educated on notification protocon including notification of the Nur Manager if the care plan or care does not accurately reflect the care	en ols se card care		
		1 had not been assisted with ording to R21's plan of care.		currently needed by the residen Education was done on 11/27/1			
	admission Minimum 8/29/13, indicated R2	ded but not limited to orie malnutrition. R21 's Data Set (MDS) dated 21 had a brief interview for) score of five, which is		The Director of Nursing and/or designee will implement correct actions for other residents poter affected by this practice includin identification via comprehensive record review specific to assistar	ntially g:		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION		E SURVEY IPLETED		
÷,	e de la companya de la companya de la companya de la companya de la companya de la companya de la companya de	245304	B. WING		DEC 2 4 2010	ا مدودوه		
NAME OF	PROVIDER OR SUPPLIER	210001		STREET ADDRESS, CITY, STAT	E. ZIP CODE Harm	<u>08/2013 (</u>		
ANGELS	CARE CENTER			300 NORTH DOW STREET CANNON FALLS, MN 55009				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE. CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE		
				needed with eating	and other ADL's.			
F 282	Continued From pa	ge 12	F 28	Residents will be re				
	nutrition alteration properties for consistency alter meals and interventing the contraction of the contract	ision dated 11/1/13, indicated: per cognitive changes, need red meats, one assist with tions: diet per physician assist to eat all meals.		conference and wit changes. The Director of Nur designee will imple	sing and/or			
	snacks three times prevent weight loss. Document review or dated 10/24/13, indicarbohydrate control	f R21's dietary progress note cated weight loss, lled diet, and meats are		ensure that this pra recur, including: Re nursing staff on pol for reporting chang condition and/or ca and re-education or	ctice does not -education of icy and procedures es in resident re plan/care card,			
	ground, between me encouraged to cons	eal snacks. R21 to be ume.	· .	temporary care plan	າ. 			
	had been sitting in a hall/lobby area from kitchen and R21 had lunch. Dietary staff a asked R21 if doing a Yeah. "R21 had Tabeans on a plate, a ounce glass of juice Tater Tot Hotdish, bi approximately three	on 11/6/13, at 11:58 a.m., R21 lining room located across the dining room located by dibeen independently eating approached R21 once and b.k. and R21 had replied "later Tot Hotdish and green dish with cake and one eight. R21 consumed one half of tes out of cake, and drank quarters of juice. No staff R21 during entire meal to complete the meal.		Nursing staff were tr to their respective re responsibilities for the aforementioned politic procedures on Nove. The Director of Nursing designee will monito actions to ensure the these actions, including care plans per week.	oles and ne cies and mber 27, 2013. ing and /or r the corrective e effectiveness of ing: Audits of 3			
	had been sitting in d hall/lobby area from kitchen independent an eight ounce glass malt-o-meal. R21 ha to go to the bathroor	on 11/7/13, at 7:19 a.m., R21 ining room located across dining room located by ly eating breakfast. R21 had of juice, cereal bowl of d stated at 7:29 a.m., I have n and left dining room. R21 boximately three quarters of		Upon completion of corrective actions, if completed immediated education will be profrom the reviews. Fareducated protocols w	applicable will be ely. Additional vided as derived ilure to adhere to			

ANGELS CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	COM		TE SURVEY MPLETED	
ANGELS CARE CENTER CALID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH DOFROCTIVE ACTION APPROPRIATE DEFICIENCY) COMPLET DEFICIENCY DEPRICE TAG CONSENSE PLAN OF CORRECTION (EACH DOFROCTIVE ACTION APPROPRIATE DEFICIENCY) COMPLET DEFICIENCY DATE CANNON FALLS, MN 55098 COMPLET DEFICIENCY COMPLET DEFICIENCY COMPLET DEFICIENCY COMPLET DEFICIENCY DATE CANNON FALLS, MN 55098 COMPLET DEFICIENCY CANNON FALLS, MN 55098 COMPLET DEFICIENCY CANNON FALLS, MN 55098 CANNON FALLS, MN 5		• .	245304	B. WING		11/	08/2013 🌈
FREEIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F-282 Continued From page 13 juice and eaten three quarters of malt-o-meal. Dietary staff person had asked R21 if finished with breakfast before exciting dining room and R21 had stated I guess so. No staff person had sat with R21 during entire meal to assist or encourage R21 to eat entire meal. During observation on 11/7/13, 12:09 p.m., an unopened container of vanilla flavored ice cream with a date of 11/7/13 on top had been on R21 's night stand, R21 had been in bed sleeping at this time. At 12:57 p.m., the ice cream remained on R21 's night stand unopened. During interview on 11/7/13, at 12:57 p.m., nursing assistant (NA)-E stated he had not offered ice cream to R21. During interview on 11/7/13, at 12:57 p.m., licensed practical nurse (LPN)-C stated kitchen staff pass out the snacks but do not assist resident 's to eat the food, nursing staff are to assist resident 's to eat snacks. LPN-C stated R21 's ice cream had been passed out by dietary staff between 10:00 a.m. and 10:15 a.m. LPN-C stated she had not offered ice cream to R21 either. During interview on 11/7/13, at 1:11 p.m., NA-D stated he had not offered ice cream to R21. During interview on 11/7/13, at 2:16 p.m., director of nursing stated she had heard at report that				3	00 NORTH DOW STREET		
F 282 Continued From page 13 Juice and eaten three quarters of malt-o-meal. Dietary staff person had asked R21 if finished with breakfast before exciting dining room and R21 had stated I guess so. No staff person had sat with R21 during entire meal to assist or encourage R21 to eat entire meal. During observation on 11/7/13, 12:09 p.m., an unopened container of vanilla flavored ice cream with a date of 11/7/13 on top had been on R21 's night stand, R21 had been in bed sleeping at this time. At 12:57 p.m., the ice cream remained on R21 's night stand unopened. During interview on 11/7/13, at 12:57 p.m., nursing assistant (NA)-E stated he had not offered ice cream to R21. During interview on 11/7/13, at 12:57 p.m., licensed practical nurse (LPN)-C stated R21 's ice cream had been passed out by dietary staff between 10:00 a.m. and 10:15 a.m. LPN-C stated R21 's ice cream had been passed out by dietary staff between 10:00 a.m. and 10:15 a.m. LPN-C stated she had not offered ice cream to R21. During interview on 11/7/13, at 2:16 p.m., director of nursing stated she had heard at report that	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	JLD BE	COMPLETION
aware of R21 's weight loss only decline in health. Director of nursing looked at R21's care plan and verified the care plan read assist of one with meals and made the comment that someone should have assisted R21 to eat the snacks and	F-282	juice and eaten thr Dietary staff perso with breakfast before R21 had stated I g sat with R21 during encourage R21 to During observation unopened contained with a date of 11/7 night stand, R21 hime. At 12:57 p.m. R21's night stand. During interview or nursing assistant (offered ice cream to be a sist of the staff pass out the staff pass out the staff pass out the staff pass out the staff between 10:0 stated she had not either. During interview or stated he had not of the staff pass out the staff between 10:0 stated she had not either. During interview or stated he had not of the staff pass out the staff between 10:0 stated she had not either. During interview or stated he had not of plan and verified the with meals and management of R21's with R21's with meals and management of R21's with	ree quarters of malt-o-meal. In had asked R21 if finished one exciting dining room and uess so. No staff person had gentire meal to assist or eat entire meal. In on 11/7/13, 12:09 p.m., an er of vanilla flavored ice cream /13 on top had been on R21 's ad been in bed sleeping at this, the ice cream remained on a unopened. In 11/7/13, at 12:57 p.m., NA)-E stated he had not to R21. In 11/7/13, at 12:57 p.m., nurse (LPN)-C stated kitchen snacks but do not assist the food, nursing staff are to one at snacks. LPN-C stated had been passed out by dietary 0 a.m. and 10:15 a.m. LPN-C offered ice cream to R21. In 11/7/13, at 1:11 p.m., NA-D offered ice cream to R21. In 11/7/13, at 2:16 p.m., director he had heard at report that ssistance lately, had not been eight loss only decline in nursing looked at R21's care need at the comment that someone and the comment that someone	F 282	The results of monitoring of the corrective actions (track, trend analysis) will be reported to the QA Committee monthly for 6 r. Upon this review, system revis and/or staff education will be implemented if indicated via a prescribed corrective action pl. Audits will be reduced based or results and recommendations the QA Committee. Facility DON will be responsible maintaining compliance. The facility alleges that it will be substantial compliance with the	d and le facility months. sions an. from from	12/18/13

FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	GDEC 2 4 2013	LETED .
		245304	B. WING _	WN Dans	8/2013 🧷
· ·	PROVIDER OR SUPPLIER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC 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 282	_Continued_Erom_pa	ge_14	F_28:	2	
	meals. Document review of AND PROCEDURE is the policy of Volut temporary care plar (Admission Individu and comprehensive 21st day of admissiothe resident 's high function possible." Document review of RESIDENT dated 20 Residents who need well-balanced meal, 483.20(m), 483.20(e FOR MI & MR A facility must coord pre-admission screed program under Med the maximum extend duplicative testing and A nursing facility mu January 1, 1989, and (i) Mental illness as (i) of this section, un authority has determindependent physical performed by a personal state mental health (A) That, because condition of the indivithe level of services and	facility CARE PLAN POLICY dated 8/2010, read, "Policy: It nteers of America to provide a within 24 hours of admission al Care Plan) and a complete care plan by the resident 's on. The care plan will ensure test level of practicable facility FEEDING A 2006, read, "Policy 1. If assistance will be fed a by RN, LPN, or CAN [NA]. E) PASRR REQUIREMENTS inate assessments with the ening and resident review locald in part 483, subpart C to a practicable to avoid and effort. It is that admit, on or after and a presidents with: It is defined in paragraph (m)(2) less the State mental health and mental evaluation on or entity other than the authority, prior to admission; of the physical and mental idual, the individual requires provided by a nursing facility;	F 285		
	(B) If the individua	I requires such level of		.	1

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDII		E CONSTRUCTION		E SURVEY IPLETED
		245304	B. WING _			11/	08/2013 (
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ANGELS	CARE CENTER				00 NORTH DOW STREET		
			1	C,	ANNON FALLS, MN 55009		
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		4.5		0.5	F- 22 C 1 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2		
F-285		_	F 28	85	Facility Social Worker will be		
·		ne individual requires s for mental retardation.			responsible for maintaining		
		ion, as defined in paragraph			compliance.		
	(m)(2)(ii) of this sec retardation or devel has determined pric (A) That, because condition of the indi	tion, unless the State mental opmental disability authority			The facility alleges that it will be substantial compliance with the standard indicated by 12/18/13	9	12/18/13
		al requires such level of					
	services, whether the	ne individual requires					
	specialized services	s for mental retardation.					
	illness" if the individ illness defined at §4 (ii) An individual is retarded" if the individefined in §483.102	considered to have "mental ual has a serious mental					
	by; Based on interview facility failed to prov preadmission scree rehabilitative assess determine mental he needed for 1 of 1 re	and document review, the ride the comprehensive level II ning and psychosocial and/or sment as required to ealth rehabilitative services esidents (R10) reviewed for ening and Resident Review creening.					
-	concerning their spe	10 lacked a level II PASRR ecialized needs for mental ual disability services.					

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			O		APPROVE . 0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DAT	E SURVEY IPLETED	1
ا ماران المراجع		245304	B. WING	S		11/	08/2013	<u></u>
	PROVIDER OR SUPPLIER			Π	STREET ADDRESS, CITY, STATE, ZIP CODE		00/2010	- \(\(\)
ANGELS	CARE CENTER	·		1	300 NORTH DOW STREET CANNON FALLS, MN 55009			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	N
F-285-	⁻Continued⁻From⁻pa	ge-16	F-:	28	5			_
	The facility identifie intellectual disability	d R10 as a resident with						
·	indicated R10 had s R10 's diagnosis pr included depression	sent form sated 12/4/12 schizophrenia a mental illness. rovided from the facility n, anxiety, paranoid moderate intellectual						
	reside in the facility PASRR was updated days in the facility. admitted 10/12/04 stays but now will be D/C 'd [discharged SW [social worker] treatment'." The LIllness or Mental Resistance certified screening form indicated intellectual disability to be completed for assistance certified screening form indicated illness diagnificationing. The Leronaud intellectual disability of the R10 had a psychiated question mark was question. The Level had intellectual disability of the R10 had a psychiated question. The Level had intellectual disability of the R10 had a psychiated question. The Level had intellectual disability of the R10 had a psychiated question. The Level had intellectual disability of the R10 had a psychiated question.	10/12/04 indicated R10 would for less than 30 days. This ed on 11/24/04 to less than 90 A note indicated R10 was "stay was thought to be <30 e <90 days. Will hopefully be in couple of weeks " "says probably no active evel I Screening for Mental etardation (changed to indicated that this form was any admission to a medical nursing facility. The Level I cated R10 did have a major cosis but did have impaired evel I screening did not note if ric treatment history as a placed in the box of this el I screening also noted R10 bility, had presenting er or behavioral issues that esence of intellectual						
.	licensed social work have a copy of the I	on 11/8/13 at 10:40 a.m. the ker (LSW) stated she did not Level II PASRR screening for LSW stated she had placed a						

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245304	B. WING		11/0	08/2013	. i
	PROVIDER OR SUPPLIER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODI 300 NORTH DOW STREET CANNON FALLS, MN 55009	=	······································	The state of the s
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 312 SS=E	screening. No copy provided. 483.25(a)(3) ADL COPENDENT RES A resident who is used aily living receives maintain good nutriand oral hygiene. This REQUIREMENT by: Based on observator review, the facility for received grooming 4 residents (R47, Refor activities of daily	ying to find a copy of a Level II y of a Level II screening was ARE PROVIDED FOR IDENTS hable to carry out activities of the necessary services to tion, grooming, and personal IT is not met as evidenced ion, interview, and document alled to ensure each resident assistance as needed for 4 of 56, R65 and R21) reviewed living (ADLs.)	F 288	Residents R47, R56, and R65, id this statement of deficiency have checked and had their nails cleater trimmed as needed. Corresponding updates have been made to the care assignment sheet and combot to the resident and/or designate maker emphasizing nail care to on bath days. The Nurse Manager on the 300 conduct on-going random audit compliance with nail care being regular basis. Staff will receive education on problem areas.	ve been aned and ading c care plan, municated ed decision be done wing will s to ensure done on a re-		
	trimming and cleanic On 10/10/13 R47's written complaint to Health related to lace received during stay written complaint in had long and dirty fiwith the director of an one of that again on and dirty fingernails that other residents long dirty fingernails R47 was admitted to	family (F)-A provided a the Minnesota Department of ck of care F-A felt R47 had y at the nursing home. The dicated that on 8/29/13 R47 's ngernails and F-A had spoken nursing. The written complaint 9/21/13 R47 again had long . The complaint also noted in the special care unit had		R21 has been reassessed for ab self. Corresponding updates ha made to the care plan, care ass sheet and communicated to the and/or designated decision mal staff responsible for care for the have been educated on notifical procedure including notification. Nurse Manager if the care plan card does not accurately reflect currently needed by the resider Education was done on 11/27/2. The Director of Nursing and Nu Managers and/or designee will	ignment e resident ker. All e resident ition n of the or care t the care nt. 13.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
711101 11111		IDENTIFICATION TO THE PARTY OF	A. BUILL	JING			
		245304	B. WING	B. WING			8/2013
	PROVIDER OR SUPPLIER CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009				
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•					corrective actions for other resident	S	
F-312	dementia. The quadated 9/12/13 indiccognitively impaired assistance with all hygiene. The care dated 6/19/13 indicunit and had diagnous anxiety, depression hip fracture. The Cassistance with AD 10/3/13 noted an inbathing as needed. The director of nurs 11/8/13 at 2:50 p.m of F-A's concerns summer. DON stawere about R47's had been disappoin concern a couple mansferred to anoth complained of R47 R56 lacked trimmin R56 was observed was noted to have nails on both hands was observed in the nails were observed under nails on both The quarterly MDS The MDS indicated impaired and required.	arterly Minimum Data Set ated R47 was severely d and required extensive ADLs including personal area assessment (CAA) ated R47 lived on the memory oses that included dementia, a, osteoarthritis and history of AAA noted R47 needed Ls. The care plan dated atervention of "nail care after" sing (DON) was interviewed on a. DON stated she was aware which were reported this last ted she remembered concerns finger nails. DON stated they not that F-A had the same nonths later. R47 had been ner home after F-A had not getting adequate cares. In and cleaning of finger nails. In and dark colored fingers of the wheelchair. R56 's fingers de wheelchair. R56 's fingers de to remain long and soiled	F	312	corrective actions for other resident potentially affected by this practice including: An audit focused on grooming and note a was completed by the Staff Development nurse for all residents Results of the audits were communited to the Nurse Managers who then four on all problems noted. A follow-up audit was done several later to assess for improvement. Problems were reported to the Nurse Manager who then followed up on problems identified. Identification of other residents potentially affected by this practice done via comprehensive record revispecific to assistance needed with eand other ADL's. Reviews will be docare conferences and with significant changes. The Director of Nursing or Nurse Managers and/or designee will impressures to ensure that this praction not recur, including: Re-education of nursing staff on poland procedure for reporting changer resident condition and or care plan,	cated llowed weeks se all will be iew eating one at at the does licy es in	
		ided 11/6/13 identified a e deficit in dressing, bathing, ed to dementia and	•		re-education on the use of the temporare plan.		

F-312 Continued From page 19 Alzheimer's evidenced by needs assistance to complete ADL's. Nursing assistant (NA)-B had been interviewed on 11/8/13 at 9:49 a.m. and stated that cutting R56 's nails sometimes takes two staff as R56 had been difficult to frim nails in the past. Clinical Manager (CM)-B was interviewed on 11/8/13 at 11:00 a.m. She indicated that staffing had been an issue for meeting the needs of the residents. Sometimes R56 refused cares, but CM-B had not been told about need for nails to be cleaned and trimmed. R65 lacked personal hygiene related to fingernails. The resident has had a bath documented on 9/11 and 10/2 on skin audit forms and nothing was written for fingernail care either time. Doming random audits on all units will be done weekly by the DON and/or designees to identify further problems related to grooming and personal hygiene. Re-education and re-direction will be given as needed if problems are noted. Staff was retrained as it relates to their respective roles and responsibilities for the aforementioned policies and procedures on 11/27/13. Facility DON will be responsible for maintaining compliance. The facility alleges that it will be in substantial compliance with the standard		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION			E SURVEY IPLETED
ANGELS CARE CENTER (A) ID SUMMARY STATEMENT OF DEFICIENCIES SON NORTH DOW STREET CANNON FALLS, MN 55009 (A) ID SEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR I.SC IDENTIFYING INFORMATION) FOR TAG STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009 PREFEX CANNON FALLS			245304	B. WING			11/	08/2013 (
Friefix TAG (ACAI DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) From the proof of the properties of the proof of the properties of the proof of the properties of the proof of the properties of the proof o				;	800 NORTH DOW STREET			
Alzheimer's evidenced by needs assistance to complete ADL's. Nursing assistant (NA)-B had been interviewed on 11/8/13 at 9:49 a.m. and stated that cutting R56 's nails sometimes takes two staff as R56 had been difficult to trim nails in the past. Clinical Manager (CM)-B was interviewed on 11/8/13 at 11:00 a.m. She indicated that staffing had been an issue for meeting the needs of the residents. Sometimes R56 refused cares, but CM-B had not been told about need for nails to be cleaned and trimmed. R65 lacked personal hygiene related to fingernails. The resident has had a bath documented on 9/11 and 10/2 on skin audit forms and nothing was written for fingernail care either time. Documentation for 10/9, 10/16, 10/23, 10/30, and 11/6/2013 identify the resident had a bath and was totally dependent. Skin check areas noted none found and there was no documentation regarding trimming of fingernails, shaving, etc. On 11/5/2013 at 3:00 p.m., R65 had long fingernails approximately 1/2 inch long and dirty underneath nails. On 11/6/2013 during the noon meal time at 12:12 p.m., R65 was observed eating cake with long dirty flooking finger nails. On 11/7/72013 at 1:30 p.m., R65 gain had been observed with long dirty fingernails. On 11/8/2013 at 9:00 a.m., R65 again was observed withle eating breakfast eating with long dirty	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE CROSS-REFERENCED	ACTION SHOULD TO THE APPROPI	BE	(X5) COMPLETION DATE
R65's care plan dated 10/28/2013 was reviewed. It noted: Self-care-deficit in dressing, bathing, and grooming due to dementia evidenced by need for		Alzheimer's evider complete ADL's. Nursing assistant (on 11/8/13 at 9:49 R56 's nails some had been difficult to Clinical Manager (11/8/13 at 11:00 a. had been an issue residents. Someting CM-B had not been be cleaned and tring R65 lacked person fingernails. The resident has had not local be cleaned and tring R65 lacked person fingernails. The resident has had 10/2 on skin at written for fingerna Documentation for 11/6/2013 identify the was totally dependent none found and the regarding trimming. On 11/5/2013 at 3:1 fingernails approximate approximate approximate and the regarding trimming. On 11/7/2013 at 1:30 pobserved with long 11/8/2013 at 9:00 at while eating breakfingernails. R65's care plan dat It noted: Self-care-of-	(NA)-B had been interviewed a.m. and stated that cutting times takes two staff as R56 or trim nails in the past. CM)-B was interviewed on m. She indicated that staffing for meeting the needs of the mes R56 refused cares, but in told about need for nails to mmed. It is all hygiene related to make an an anothing was ill care either time. 10/9, 10/16, 10/23, 10/30, and the resident had a bath and ent. Skin check areas noted ere was no documentation of fingernails, shaving, etc. 10/0 p.m., R65 had long mately 1/2 inch long and dirty on 11/6/2013 during the noon p.m., R65 was observed and dirty fingernails. On a.m., R65 again had been dirty fingernails. On a.m., R65 again was observed ast eating with long dirty ted 10/28/2013 was reviewed. It deficit in dressing, bathing, and	F 312	done weekly by the DC designees to identify for related to grooming and Re-education and re-digiven as needed if probability. Staff was retrained as in respective roles and rethe aforementioned poporcedures on 11/27/11. Facility DON will be resimal maintaining compliance. The facility alleges that substantial compliance.	ON and/or urther proble of personal hirection will be blems are not trelates to the sponsibilities olicies and a ponsible for e. it will be in	ms ygiene. e ed. neir for	12-18-1-3

CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245304				0	OMB NO. 0938-0391		
					CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED	
			B. WING			11/0	08/2013 <i>(</i> /	ļ.,
	PROVIDER OR SUPPLIER CARE CENTER			30	REET ADDRESS, CITY, STATE, ZIP CODE 0 NORTH DOW STREET ANNON FALLS, MN 55009			
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F-31 <i>2</i> -	-Gontinued-From-pa	nne-20	F-	312		:		
	Bathing: 1 assist to independence with bathing as needed nurse. PERSONAL	complete. Encourage upper body. Nail care after Report any changes to the HYGIENE: 1 assist to burage independence with		9-1-Z-1-				
	as severely cognitive tensive assist of activities of daily live. On 11/7/2013 at 1:	10/11/2013 identified resident vely impaired and required one staff for personal hygiene ring. 15 p.m., nurse aide (NA) - G do resident nails on bath days						
	which were weekly On 11/8/2013 at 10 manager (CNM)-B		·				ĺ (
	needed. The policy entitled dated 2006 noted to cleanliness, prever to prevent skin proinclude the frequer policies entitled Barbath (bed) dated 2	Nails Care of (Finger and Toe) he purpose as to provide nt spread of infection, comfort, blems. The procedure did not ncy of nail care. The facility th (partial) dated 2006 and 006, directed staff to "care of nails is part of the bath."					•	
	R21 had not been according to R21's	assisted with meals or snacks plan of care.						
	diagnoses that incl diabetes, protein-c carcinoma of prost Data Set (MDS) da	nitted on 8/22/13 with uded but not limited to alorie malnutrition, and ate. R21's admission Minimum ated 8/29/13, indicated R21 had mental status (BIMS) score of ve impairment.		-				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			(<u> </u>	0938-0391
TATEMENT ND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION		E SURVEY PLETED
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	PROVIDER OR SUPPLIER CARE CENTER			3	STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009		
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F-312	-Continued-From-pa	ge-21	F=:	312		,	
•	focus: nutrition alte need for consistend with meals and inte	vision dated 11/1/13, indicated ration per cognitive changes, by altered meats, one assist erventions: diet per physician assists to eat all meals.		:			
		rders dated 10/30/13, aree times daily between meals oss.				·	·
	dated 10/24/13, incontrolled diet, and	of R21 's dietary progress note licated weight loss, carb meats are ground, between to be encouraged to consume.	-		·		·
	had been sitting in hall/lobby area from kitchen independer approached R21 or and R21 had replied Tater-Tot Hotdish a dish with cake and R21 consumed one bites out of cake, a	on 11/6/13, at 11:58 a.m., R21 dining room located across in dining room located by antly eating lunch. Dietary staff ince and asked R21 if doing oke dyeah, good. R21 had and green beans on a plate, a one eight ounce glass of juice. It half of Tater-Tot Hotdish, and drank approximately three to staff person had sat with meal to assist R21.		-			
	had been sitting in hall/lobby area from kitchen independer an eight ounce glassmalt-o-meal. R21 to go to the bathroomad drunk approximand eaten three question and eaten three from hall from the sitting in the sittin	dining room located across of dining room located across of dining room located by hely eating breakfast. R21 had see of juice, cereal bowl of had stated at 7:29 a.m., I have som and left dining room. R21 mately three quarters of juice parters of malt-o-meal. Dietary seked R21 if finished with					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

		AND HUWAN SERVICES & MEDICAID SERVICES		•	OI		APPROVE 0938-039	
STATEMENT	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		E CONSTRUCTION		E SURVEY PLETED	
÷		245304	B. WING			11/	08/2013	1
	PROVIDER OR SUPPLIER CARE CENTER			30	REET ADDRESS, CITY, STATE, ZIP CODE 10 NORTH DOW STREET ANNON FALLS, MN 55009			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	N
F-312-	-Continued-From-pa	ne-22	F-:	312				_
	breakfast before ex had stated I guess with R21 during ent	citing dining room and R21 so. No staff person had sat ire meal to assist R21.						
	unopened containe with a date of 11/7/ night stand, R21 ha	on 11/7/13, 12:09 p.m., an r of vanilla flavored ice cream 13 on top had been on R21's ad been in bed sleeping. At cream remained on R21's ed.						
		11/7/13, at 12:57 p.m., NA)-E stated he had not o R21.						
	licensed practical n staff pass out the si resident's to eat, nu eat snacks. LPN-C been passed out by	11/7/13, at 12:57 p.m., urse (LPN)-C stated kitchen nacks but do not assist ursing staff assist resident's to stated R21's ice cream had dietary staff between 10:00 is LPN-C stated she had not p R21.						
		11/7/13, at 1:11 p.m., NA-D ffered ice cream to R21.						
	of nursing stated sh R21 needs assistant loss only decline in looked at R21's caread assist of one was	11/7/13, at 2:16 p.m., director ne had heard at report that nce lately, not aware of weight status. Director of nursing are plan and verified care plan with meals and stated so yes, assisting with snacks and						
	RESIDENT dated 2	f facility FEEDING A 2006, read "Policy 1. Residents be will be fed a well-balanced						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		3	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245304	B. WING		11/08/2013	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET	<u> </u>	1
ANGELS	CARE CENTER			CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFINE DEFICIENCY)	D BE COMPLETION	
E-240-		~~ 0.2	F-24	0		- -
F 312 F 318 SS=D	meal, by RN, LPN, resident that you ar the feeding, staff to convenient for both	or CNA. Procedure 8. Tell the re going to be seated during position chair where it will be them and the resident." EASE/PREVENT DECREASE	F 31	Resident # R52 identified in this st of deficiency has been reassessed services related to range of motioupdates were made to the care pl	for n and an and	
	Based on the compresident, the facility with a limited range appropriate treatmerange of motion and decrease in range of this REQUIREMENT by: Based on observative review, the facility formation services (Regular and the compression of the c	orehensive assessment of a must ensure that a resident of motion receives ent and services to increase d/or to prevent further of motion. NT is not met as evidenced tion, interview, and document ailed to provide range of OM) as recommended by the or 1 of 3 residents (R52)		care card as needed by the Nurse Managers. Nursing staff was re-educated on 11/27/13 on the importance of fo the residents' plan of care, which any restorative nursing orders or recommendations. Education was done on the importance of consist charting cares, including any restorating cares, including any restorations or recommendations from the responsible or nursing. The Nurse Managers have reviewed charts and care plans for any residuals.	illowing includes s also tently brative om	
	Findings include: R52 did not receive or use the hand/fing the physical therap R52 was observed in bed and on 11/08 observed sitting in to open right hand, out fingers on right present. During ob 8:30 a.m. to 9:00 a	the range of motion services ger splint as recommended by		a Range of Motion program or with assistive devices currently being use made changes to the care plans a cards as needed. Nursing staff was re-educated on 11/27/13 on the importance of for the residents' plan of care, which any restorative nursing orders or recommendations. Education was done on the importance of chartic including any restorative program recommendations from therapy of pursing	th used and nd care ollowing includes us also ng cares, us or	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE SU COMPLE	
		245304:	B. WING		11/08/2	.013 🥝
NAME OF PROVIDER OR SUPPLIER ANGELS CARE CENTER			3	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE CO	(X5) MPLETION DATE
F-318	extremity joints to stransfer with the E-right hand splint and provided or offered During an interview stated no range of thand had been donstaff had done range moved right leg back. During an interview nursing assistant (No contracted hand shocares, but no range therapy would do it, use a splint becaus rag. R52 's ROM document amour ROM. Restorative upper extremity 10 Documentation of R10/9/13 through 11/been done inconsis The Therapy to Nurul/2/13 indicated pasarms twice a day. Right is bedtime and off in million. Clinical Manager (C11/7/13 at 12:30 p.m.)	ng. R52 could move all upper ome extent and was able to Stand lift. R52 did not utilize a d no range of motion was during this time. on 11/7/13 at 11:12 a.m. R52 motion to contracted right e by staff. R52 stated that e of motion to leg as R52 sk and forth. on 11/7/13 at 11:15 a.m. IA)-A stated that the ould be washed with morning of motion is done because NA-A then said they don't e they had used a rolled up mentation indicated staff was at of minutes they provide Passive Range of Motion right repetitions twice a day. COM provided to R52 from 6/13 was provided and it had tently during this time. sing Communication dated ssive range of motion right and lower extremity stretches and contracture splint on at morning. eM)-A was interviewed on CM-A stated she had	F 318	The Director of Nursing and/or will implement measures to en this practice does not recur, incroutine monitoring of the resid restorative programs/recomme by the Nurse Managers to ensurgoing compliance. Resident's mobility needs will reviewed quarterly at care conflict meetings. In addition, random audits will least 3 times weekly for 3 montresidents receiving a restorative or assistive device to determine compliance. The Director of Nursing and /or will monitor the corrective active ensure the effectiveness of the including: Upon completion of reviews/accorrective actions, if applicable completed immediately. Additeducation will be provided as defrom the reviews. Failure to additeducated protocols will result in corrective counseling. The results of monitoring of the actions (track, trend and analyst reported to the facility QA Comments.)	sure that cluding ent's endations are on- be ference and be done at ths on e program e designee ons to se actions, udits, , will be ional erived lhere to n	
	found a computer p motion documentati	roblem with the range of on. On 4/2/13 physical	·	monthly for 6 months. Upon the system revisions and/or staff ed	nis review,	

I DENTIFICATION NUMBER			*	COMPLETED
	245304	B. WING		11/08/2013
NAME OF PROVIDER OR SUPPLIER ANGELS CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 300 NORTH DOW STREET CANNON FALLS, MN 55009	DDE .
EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	Y FACH CORRECTIVE ACTION	SHOULD BE COMPLETION
inggrand-Frustma-wa-				i
mity range of to be worn or nation had no plan. Therefo ROM complete 25(h) FREE O	motion and a hand contracture in the right hand/fingers. This it been transferred to R52 's re only the upper extremity ed. F ACCIDENT		Audits will be reduced base compliance and recommenthe Medical Director and Quarter Facility DON will be response	d on dations from A Team.
facility must er onment remai possible; and uate supervisi	nsure that the resident ns as free of accident hazards each resident receives		The facility alleges that it w	•
ed on observa acility failed to and develop ring accidents wed for accidents mass include: For resulting in a and. Howeve oughly investig rs and based wentions had revent further of ent report date p.m.) for R67 rted that R67 had with disco	tion, interview and documents, thoroughly investigate an interventions to minimize of for 1 of 3 residents (R67) ents. R67 had injury of unknown fracture to the index finger of r, the incident had not been ated to determine causal on this investigation not been developed to minimize occurrences. Red 9/28/2013 and time of 13:14 was reviewed. A nurse and a swollen index finger on oloration to site. The resident	F325	and charting to determine prob inconsistencies or if further investindicated. Corresponding upda made to the care plan and care sheet and communicated to the and/or designated decision mal Staff responsible for the care of have been re-educated on the procedure for reporting and invincidents. The Director of Nursing and/or implement corrective actions for residents potentially affected be including: a review of resident or those residents who have had reinjuries was completed to determine the corrective actions for inconsistencies or if further indicated. Further follow-up with indicated and the care plan and be updated.	lems or estigation was tes have been assignment e resident eer. the resident colicy and restigating designee will or other y this practice ecords for eccent falls or mine problems nvestigation is ll be done as care card will
F THE STATE OF THE SECOND STATES	ER OR SUPPLIER E CENTER SUMMARY STATEACH DEFICIENCY OR LEGULATORY OR L	ECENTER SUMMARY STATEMENT OF DEFICIENCIES FEACH DEFICIENCY MUST BE PRECEDED BY FULL EEGULATORY OR LSC IDENTIFYING INFORMATION) Sinued From page 25 Emity range of motion and a hand contracture to be worn on the right hand/fingers. This mation had not been transferred to R52 's plan. Therefore only the upper extremity ROM completed. 25(h) FREE OF ACCIDENT ARDS/SUPERVISION/DEVICES facility must ensure that the resident ronment remains as free of accident hazards possible; and each resident receives quate supervision and assistance devices to	TECTION 245304 B. WING ER OR SUPPLIER E CENTER SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION) Intued From page 25 Emity range of motion and a hand contracture to be worn on the right hand/fingers. This mation had not been transferred to R52 's plan. Therefore only the upper extremity ROM completed. 25(h) FREE OF ACCIDENT ARDS/SUPERVISION/DEVICES facility must ensure that the resident ronment remains as free of accident hazards possible; and each resident receives puate supervision and assistance devices to ent accidents. F32. REQUIREMENT is not met as evidenced ed on observation, interview and documents, acility failed to thoroughly investigate an y and develop interventions to minimize rring accidents for 1 of 3 residents (R67) eved for accidents. F32. REQUIREMENT is not met as evidenced ed on observation, interview and documents, acility failed to thoroughly investigate an y and develop interventions to minimize rring accidents for 1 of 3 residents (R67) eved for accidents. Ings include: R67 had injury of unknown in resulting in a fracture to the index finger of land. However, the incident had not been oughly investigated to determine causal ors and based on this investigation eventions had not been developed to minimize revent further occurrences. Ident report dated 9/28/2013 and time of 13:14 to p.m.) for R67 was reviewed. A nurse reted that R67 had a swollen index finger on land with discoloration to site. The resident	RECTION TOENTIFICATION NUMBER: 245304 B. WING

FORM APPROVED
OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	Market Land	245304	B. WING _		11,	اا 08/2013 (
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		\.	
ANGELO	CADE OFFICE			300 NORTH DOW STREET			
ANGELS	CARE CENTER			CANNON FALLS, MN 55009			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION	T (VE)	
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		ILD BE	(X5) COMPLETION DATE	
E 323	Continued From	0C	- 00	practice does not recur, including:			
	-Continued-From-pag	-	——⊦ . 32	Ongoing weekly audits of at least 3 in	icident		
	had some pain. On	10/2/2013, nursing assistants		reports to determine compliance wit			
		ted resident had not been		facility's policy and procedure for rep	orting		
		t few days but does have		and investigating of resident incident	s.		
	finger is an near day	Jursing assistants report		Immediate re-education of staff will I	oe .		
	would not have had	ninant hand and therefore to strike out hard enough to ident unable to recall what		completed if problems or inconsisten found.	cies are		
	hannened but staff r	eport resident would be able		The procedure for reporting and inve	stigating		
		f someone had hurt him. Due		incidents has been revised to provide			
		r is on weak side theory of		consistency and include more of the	more		
		angled and got caught in		interdisciplinary team in the decision	making		
		esident unable to propel		process.	maxing		
	wheelchair but staff	did not report resident had		1'			
	yelled out during trai	nsfer or in bed.		Staff education was done on 11/27/1]	
	Interdisciplinary tear	m (IDT) reviewed incident for		review the facility policy and procedu	re on		
	9/28/2013 at 13:14.	Incident reported to Office of		reporting and investigating.		1	
		Compliant and to Common		The Director of Nursing or Administra		17	
	Entry Point.			Social Worker will monitor the correc		1	
	D67's oppus Minima	Data Cat data d 0/0/0040		actions to ensure the effectiveness of	these	1	
		um Data Set dated 8/6/2013		actions, including:			
		lentified the resident with		Upon completion of reviews/audits, o	orrective		
	assistance of 2 staff	paired and required extensive to total assistance for		actions, if applicable will be complete		1	
	activities of daily livir			immediately. Additional education w			
į	activities of daily livil	19.		provided as derived from the reviews	. Failure		
	On 11/4/2013 at 2:09	9 p.m. and 3:02 p.m., a		to adhere to educated protocols will r	esult in		
	licensed practical nu	rse (LPN)-D was interviewed		corrective counseling.			
		ore a splint on the left index		The results of monitoring of the corre	ective		
,	finger. On asking L	PN-D if they or the NA		actions (track, trend and analysis) wil			
	concerning R67 's fr	actured finger LPN-D said		reported to the facility QA Committe			
		idn't know how it happened.		for 6months. Upon this review, syste			
•				revisions and/or staff education will be			
		a.m., a clinical nurse		implemented if indicated via a prescr	- 1		
	manager, registered			corrective action plan.			
		g the incident. Said that R67		· ·	Morker		
		igh investigation to determine		Facility Director of Nursing and Social	worker		
		the injury and did not put		will be responsible for maintaining		1	
		e to prevent further injury or	•	compliance.		4.611	
	new injuries from occ	curring.		\perp The facility alleges that it will be in su	bstantial	12/18/13	

PRINTED: 12/11/2013 FORM APPROVED OMB NO. 0938-0391

		CHIEDIOTED CENTROLO				MID NO.	. 0000-000 [
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245304	B. WING	·		11/	08/2013 (
	PROVIDER OR SUPPLIER CARE CENTER			3	STREET ADDRESS, CITY, STATE, ZIP CODE 800 NORTH DOW STREET CANNON FALLS, MN 55009	:	- Angel
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
SS=D	Each resident's drug unnecessary drugs. drug when used in eduplicate therapy); without adequate mindications for its us adverse consequents should be reduced combinations of the Based on a comprehensident, the facility who have not used agiven these drugs untherapy is necessary as diagnosed and derecord; and resident drugs receive gradu behavioral interventic	g regimen must be free from An unnecessary drug is any excessive dose (including or for excessive duration; or onitoring; or without adequate e; or in the presence of ces which indicate the dose or discontinued; or any reasons above. The ensive assessment of a must ensure that residents antipsychotic drugs are not nless antipsychotic drug y to treat a specific condition ocumented in the clinical s who use antipsychotic all dose reductions, and	F		Resident(s)-R56-and-R8-identified-ir statement of deficiency have been reassessed for use of non-pharmacinterventions before administering meds for pain and anxiety. Resident was reassessed for use of non-pharmacological interventions before administering PRN sleep medications. Corresponding updates have been not to the care plan and care cards and communicated to the resident and/designated decision maker. Nursing was educated on 11/27/13 on facility policy and procedure for offering not pharmacological interventions prior administering PRN medications for spain or anxiety and documenting interventions, to include effectiveness. The Director of Nursing, Nurse Manand/or designee will implement the corrective actions as noted above for other residents potentially affected practice.	ological PRN at R8 are as. made for g staff ty on- to sleep, ess. agers same or all	
	by: Based on interview failed to ensure use interventions had be administration of as medications and pairesidents (R8, R56) and pairesidents (R8, R56).	n medications for 2 of 5 and failed to assess for sleep 5 residents (R8) reviewed for		- - -	Resident care plans will be updated quarterly and with significant change non-pharmacological preferences wadded to the care plans. The Director of Nursing or designee implement measures to ensure that practice does not recur, including resofthe EMAR, to include a pop-up	will this	

reminder to offer non-pharmacologic

FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245304	B. WING			11/08/2013	
	PROVIDER OR SUPPLIER CARE CENTER		•	3	STREET ADDRESS, CITY, STATE, ZIP CODE 800 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F_329	Continued From pa	ge 28	F:	329.	interventions prior to administering	g a	
	Findings include: R pain medications (T first attempting non- R8 received antidep	18 received as needed (PRN) ylenol and oxycodone) without pharmacological measures. oressant medication omnia without being assessed			medication. A list of possible interventions is included. Medical Records or designee will be responsible for adding the reminde EMAR for all newly admitted reside	r in the	
	diagnoses that includementia, osteoarth chronic pain. The qualification (MDS) dated 8/20/1 sleeping, received seceived PRN medianon-medication interpain and pain intensinterview of mental sof 15 on the MDS are cognitive impairment. During review of R8 dated 10/30/13, reves 5 milligrams (mg) events are consistent of the medical second of the medical s	rventions for pain, frequent ity score of 10. R8's brief status (BIMS) had been 9 out not indicated moderate t. s current physician orders ealed an order for oxycodone very six hours PRN for			A review of the revised policy by the Medical Director and QA Committee be conducted to determine if policies meet current standards of practice. All nursing staff was trained on 11/2 as it relates to their respective roles responsibilities for offering non-pharmacological interventions, inclunon-pharmacological interventions appropriate for the Nursing Assistantilize. A list of non-pharmacological	e will es 27/13 s and uding nts to	
	breakthrough pain, hours PRN for pain a bedtime for depressing During review of R8' 9/24/13, identified prand directed nurses non-pharmacologica packs, cool packs, retechniques PRN. At directed staff to encoactiveness during dathree p.m. and providuagnosis of insomn	rylenol 650 mg every four and Trazodone 50 mg at ion with insomnia. s care plan review date oblem of impaired comfort to offer non-medication (or I) interventions such as warm epositioning, distraction risk for interrupted sleep and			interventions, including suggestions the Empira Restorative Sleep Vitalit Program, will be available at each n station as a reference for all staff. The Director of Nursing, Nurse Man and/or designee will monitor the corrective actions to ensure the effectiveness of these actions by completing audits on at least 3 reside every week to ensure non-pharmacological interventions are butilized and documented.	y ursing agers	

STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
245304		B. WING	B. WING			11/08/2013	
	PROVIDER OR SUPPLIER S CARE CENTER			3	STREET ADDRESS, CITY, STATE, ZIP CODE 500 NORTH DOW STREET CANNON FALLS, MN 55009	1 130	100/2013 1
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	· ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERTY)	BE	(X5) COMPLETION DATE
	record and progress documentation sheel noted from the date R8 had had receive Tylenol with no documon-pharmacological prior to administration oxycodone with no conon-pharmacological prior to administration Review from the data 11/7/13: R8 had reconon-pharmacological prior to administration four doses of PRN of documentation of notinterventions attempto During interview on registered nurse (RN hours of sleep for dial when a medication is verified no sleep mo R8. During interview on stated should offer renon-pharmacological PRN pain medication non-pharmacological During interview on director of nursing stassessment to be do medication for sleep	I's medication administration of notes of PRN medication ets the following had been so of 10/4/13 through 10/31/13: did a total of four doses of PRN umentation of all interventions attempted on and two doses of PRN documentation of all interventions attempted on for one of two doses. The set of 11/1/13 through eived a total of two doses of a documentation of all interventions attempted on for one of two doses and oxycodone with no on-pharmacological ted for three of four doses. 11/7/13, at 8:38 a.m., 13)-C stated should monitor agnosis of insomnia and so started for sleep. RN-C initoring had been done for 11/8/13, at 10:38 a.m., RN-C expositioning at minimum for 1 intervention prior to giving an RN-C verified not charting 1 interventions.	F3	329	-Upon-completion-of-reviews/audits corrective actions, if applicable will completed immediately. Additional education will be provided as deriving from the reviews. Failure to adhere educated protocols will result in concounseling. The results of monitoring of the conactions (track, trend and analysis) were revisions and/or staff educated will be implemented if indicated via prescribed corrective action plan. Frequency of the audits will be reducted based on compliance and per recommendations from the QA Committee. Facility DON will be responsible for maintaining compliance. The facility alleges that it will be in substantial compliance with the staindicated by 12/18/13.	be il ed e to rrective vill be tee eview, ition a	

		AND HUIVIAN SERVICES				M APPROVED 0. 0938-0391
STATEMENT	TEMENT OF DEFICIENCIES OPLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:		(X2) MUI A. BUILD	li co	DATE SURVEY COMPLETED	
	and the same and the same	245304	B. WING	i		//08/2013 (
NAME OF	PROVIDER OR SUPPLIER			S.	TREET ADDRESS, CITY, STATE, ZIP CODE	(
ANGELS	CARE CENTER		•	1	00 NORTH DOW STREET ANNON FALLS, MN 55009	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E-220-	-04			0.0.0		
F-329		<u> </u>	F :	329		
	non-pharmacologic	on and to document the al interventions.				
	AND MANAGEMENT It is the policy for Withat all residents had pain assessment at residents will be exhistory of pain for the quarterly, with a significant with new onset of policy bata will be collected staff interviews and	f facility PAIN EVALUATION NT dated 2010, read "POLICY colunteers of America (VOA) live the right for appropriate and pain management. All aluated for indicators or a ane MDS 3.0 on admission, anificant change in status, and otential pain or discomfort. and through resident interviews, observations."		-		
	sleep, none had be					
•	R56 received antial without documental non-pharmacologic					
	diagnoses that inclu	memory care unit and had uded Alzheimer 's disease and vioral disturbances.				
	give 1 tablet by mo	n ' s order for Ativan 0.5 mg uth every 4 hours as needed lessness and lorazepam				

solution 2 mg/ml give 0.5 mg by mouth every 4 hours as needed for agitation and restlessness. The physician orders lacked symptoms of agitation and restlessness for which the antianxiety medication was to be given and lacked directions related to non-pharmacological

interventions to be attempted first.

The care plan provided 11/7/13 identified a problem of alteration in thought process related to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245304	B. WING		·	14/	08/2013
NAME OF	PROVIDER OR SUPPLIER	L		s	STREET ADDRESS, CITY, STATE, ZIP CODE		00/2010
					00 NORTH DOW STREET		
ANGELS	S CARE CENTER			c	CANNON FALLS, MN 55009		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	L	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX		(EACH CORRECTIVE ACTION SHOULD	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
F-329			F 3	329			
		viors. The target behaviors	<i>,</i> *				
		onfusion, looking for "dad", ooms at times, may refuse					
		ires, may have verbal					
		nts of being afraid, anxiety,					
		ents towards others, agitation,					
		ss, physical abuse towards					·
		interventions did not identify					
•		al interventions to try prior to dimedication. Additional					
	, ,	in the care plan included :					
		edirection, reassurance,					
		w resident time to express her			·		
	feeling, frustrations,	and sadness.					
	In October DE6 reco	eived 4 doses of as needed				ļ	
		the behavior documentation					, '
		ss notes for October did not					(
		or non-pharmacological			·		1
		orior to the as needed					
	anti-anxiety medica	tions.					
	During on intention	on 11/9/12 of 1:20 n m					
		on 11/8/13 at 1:20 p.m. :M)-A stated staff should					'
		rmacological interventions on					
	the progress notes.						
F 353		ENT 24-HR NURSING STAFF	F 3	53	Resident R66's care plan was		
SS=E					reviewed and updated to include		
					interventions for staff to assist at	.	
		ve sufficient nursing staff to			mealtime with cues, prompts and		
		related services to attain or t practicable physical, mental,			assistance as needed. R37's care p	1	
		ell-being of each resident, as			was reviewed and updated to inclu	de	
		ent assessments and			interventions for staff to assist at	;	
	individual plans of c				mealtime with cues and prompts to	, [
				ļ	keep resident awake and to assist	: 1	
		ovide services by sufficient			with eating if needed. R65's care	:	
	numbers of each of	the following types of	•		nlan was reviewed and undated to	; [

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	245304				11/08/2013	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ANGELS	CARE CENTER			300 NORTH DOW STREET		1
ANGLLO	OAKL OLNILK	•		CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLET	
				include interventions for staff to p	ut	
353-	-Continued-From-pa		F-353	dentures in before meals and to		
		hour basis to provide nursing		provide cues, prompts and assista	nce .	
		s in accordance with resident		with eating as needed. R63's care		
	care plans:			plan was reviewed and updated to	'	l
	Except when waive	ed under paragraph (c) of this		include interventions for staff to		
		urses and other nursing		provide cues, prompts, redirection		
	personnel.			and assistance as needed at mealt	l l	ŀ
	-	d d - a n - a - a - a - b (a) - 5 th is		R38's care plan was reviewed and		
		ed under paragraph (c) of this must designate a licensed		updated to include interventions f	or ·	ĺ
·		charge nurse on each tour of		staff to assist at mealtime with cu	1	l
	duty.			prompts and assistance as needed		
	-	·		R73's care plan was reviewed and		
	TI: DECLUDENCE			updated to include interventions f	or	.
	this REQUIREMENT by:	NT is not met as evidenced		staff to prepare resident for meals		l
		tion, interview, and document		and provide redirection, prompts,	:	•
		ailed to ensure sufficient		cues and assistance as needed.		(
	staffing to meet the	needs for 17 of 17 residents		In addition, the following		Ĩ.
		nit and 59 total residents in the of the survey.		interventions will be implemented	on .	- 1
	facility at the time of			the 300 wing. 1. Meal trays will be	1	
	Findings include: R	66, R63, R65, R68, R37, R73		placed in the food cart according t	1	ł
		ely assistance during meals.		seating, not by diet. 2. A current		.
-		init was observed during the		seating chart will be maintained b	, :	1
	noon meals of 11/4/	/13 and 11/6/13.		the Nurse Manager for all meals.		
	0.444401: 0			The Nurse Manager or Charge Nu	1	
		he noon meal 16 residents		for the unit will be responsible for	1.411	Ì
		care dining room. It was rt of the meal that no resident		calling for additional assistance at		
		shed before meals were		meal time if needed. 4. All staff v	rill .	
	served to the reside	ents and several of the		be re-educated on the correct		- 1
	residents used their	fingers to eat their foods.		procedures to be used during mea	4	
	On 11/6/0010 -1-10:	20 n m 16 residents		service, including: completing one		
		:29 p.m. 16 residents were in ning room with one nursing		table before starting another, crea	eating	
		se, cue, and feed. A nursing		a calm, quiet environment, wașhi		
		esident room to feed that		hands before and after meals, kee		-
		sed practical nurse assisted		nands before and after meals, kee	hing	

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	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` <i>'</i>	LE CONSTRUCTION :	(X3) DATE SURVEY COMPLETED	
		245304	B. WING	<u> </u>	11/08/	2013
_	PROVIDER OR SUPPLIER CARE CENTER		;	STREET ADDRESS, CITY, STATE, ZIP CODE 800 NORTH DOW STREET CANNON FALLS, MN 55009	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX · TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE C	(X5) OMPLETION DATE
F 353	residents to eat. R66 had not been a R66 was not assiste at the table ate inde on table and not ass minutes. On 11/6 food tray at 12:15 p eat and soon fell as staff encouraged or 12:43 p.m. which ha Quarterly Minimum 8/12/2013 identified impaired and requir eating. R63 had not been of with fingers verses not checked for colo minutes from the tin the unit and when R 11/6/13 R63 receive R63 's food tray ha served to them for 2 was observed to be food was placed in the 12:33 p.m. R63 tool some after this R63 unto the plate and g	ge 33 assisted to eat. On 11/4/13 and to eat while other residents be pendent. R66 sat with food sistance for a total of 37 //2013 R66 again received a .m. and made no attempt to leep in the wheelchair. No assisted R66 to eat until and been 28 minutes A Data Set assessment dated R66 as severely cognitively led extensive assist of one for sued to eat, not to eat cake using a fork and foods were diness after setting for 38 and the food was delivered to least a meal tray at 12:15 p.m. In the dominutes prior to this. R63 aleeping from the time the front of her until she awoke at the milk and started drinking dumped the piece of cake trabbed the cake with her no staff cueing to encourage	F 353	A management staff person will be assigned to the 300 wing at meal to monitor and assist as needed. R47, R56 and R65 were checked by the Nurse Managers and had their nails trimmed as needed. An audit was done on all residents assess personal hygiene including: grooming, nail care and shaving needs. Nurse Managers were informed of problems identified. A second audit will be completed by 12/18/13 to determine if there was improvement in the overall results the audits. Areas of concerns will then be addressed by the Nurse Managers and/or DON. The Director of Nursing or Administrator and/or designee will implement measures to ensure the staffing numbers are sufficient to provide safe care in accordance wire.	to san of the th	
	R63 to eat the meal or to use a fork to endated 9/6/2013 iden cognitively impaired cueing after set up or R65 had been obsehand during the means.	when it was set in front of her at the cake. A quarterly MDS tified resident as severely and required supervision and	·	the residents' plan of care including. The staffing coordinator and DON of develop a staffing binder for the nursing stations that will contain pertinent staffing information to as with calling staff to fill open shifts. The staffing coordinator and DON	will ssist	
		g the poor meet on 11/6/13 to		created a list of options to be used	IT	

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ł	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILD	ING.			اسر
		245304	B. WING		·	111	08/2013
NAME OF	PROVIDER OR SUPPLIER	• •			TREET ADDRESS, CITY, STATE, ZIP CODE		` 1
ANGELS	CARE CENTER	•	i		00 NORTH DOW STREET		
ANOLLO	OAKE CERTER			С	ANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
F_353-	-Continued-From-pa	ge-34	/ F-3	553	there is a call-in or for any staffing	:	
	•	nile clutching her dentures, eat	' 3	,55	situation that requires additional	÷	
		te food out of her mouth and			assistance. This plan utilizes night	ŧ	
-		plate. During the entire meal			shift staff, management staff, and		
		12:27 p.m. R65 had not been			non-nursing staff to assist with get		
		f to use her bottom denture to			residents up and dressed, assisting		
		d they encouraged her to use			with eating, etc.		
		oods provided. During an 3 at 8:30 a.m. licensed			The DON will meet at least weekly	•	
-		N)-D stated staff was to			with the staffing coordinator to		
		vear the dentures while eating.			review staffing needs. The DON w	ill	
		orning, R65 was again			meet at least weekly with the		
		ne denture in her hand. When			Administrator to give updates on		
:		place the dentures in the			current staffing needs and/or		
		I LPN-D to do so and did not so for the rest of the meal.			problems.	•	·
	remove the delitate	is for the rest of the meal.					1
	R38 was not assiste	ed during dining in a timely			Staffing questions or concerns will	pe	1
		3 at 12:25 p.m. R38 was			addressed at monthly Resident		1
		hat had arrived on the unit 13			Council and Family Council.		
		ne resident made no attempt assisted the resident for 17		\$	Nursing Staff was re-educated on		
		at time the resident played			procedure and expectations for fil	ling	
		otector while other residents at			open shifts due to call-ins	•	
		rterly minimum data set 10/6/2013 identified resident			The Director of Nursing and		
		ely impaired and required			Administrator and /or designee w	ill	
	limited assist of one	staff for eating.			monitor the corrective actions to	•	
					ensure the effectiveness of these		1
		tently cued nor assisted to eat all on 11/6/13. The food plate			actions, including:	•	
	sat in front of her for	r 21 minutes before staff sat		ł	Call Light Audits will be done wee	kly	
		A quarterly MDS dated			by staff and residents for 3 month	s to :]
`		he resident as moderately			determine problems, patterns,	:	
	cueing of one staff f	and required supervision and			perceptions, or specific areas in n	eed .	•
	caoning of one ordin				of further action. Audit frequency		
1		ed in a timely manner during			be reduced based on compliance	and	
.	the noon meal on 11	1/4/13. R73 received her food			recommendations from the QA		
	30 minutes after it a	rrived on the unit During this		1	Committee		1

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION		TE SURVEY MPLETED	
		245304	B. WING		11/	11/08/2013	
	PROVIDER OR SUPPLIER		3	STREET ADDRESS, CITY, STATE, ZIP COD 800 NORTH DOW STREET CANNON FALLS, MN 55009			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F-353	observed to propel dining room as the R82 and R56 were pound on the table. On 11/4/2013 at 1:41/7/2013 at 9:00 a regarding dining observed it had residents to wait to staffing. LPN-D sanursing assistant a shift for 17 resident assistance. The resistance. The resistance as they can great that the staff had the table too busy during the residents assisted to behaviors closely do too busy during the residents assisted to behaviors closely do busy during the residents assisted to behaviors closely do busy during the residents assisted to behaviors closely do busy during the residents assisted to behaviors closely do busy during the residents assisted to behaviors closely do busy during the residents assisted to behaviors closely do busy during the residents assisted to behaviors closely do busy during the residents assisted to behaviors closely do behaviors clo	the 12:45 p.m.) R73 was the wheelchair about the other residents ate. Residents noted to yell at R73 and then for extended periods of time. 45 p.m. and again on i.m., LPN-D was interviewed reservations on 11/4/13 at noon. If been normal for some of the eat because of the short id that they usually staffed one and one nurse during the day is who needed quite a bit of sidents are assisted to eat as et around to them. LPN-D adn't always been able to be eat as they should have been able to monitor resident uring dining because it was dining meal to just get to eat. INCE WITH GROOMING AND ple of R47, R56, R65 had not care as they all three had long had not been cleaned nor CONCERNS WITH LACK DVED ONES ON THE	F 353	Resident-Interviews-will-be-corby the DON or Administrator a designee weekly with at least residents to determine curren problems and perceptions. At will be done for 3 months and frequency will then be reduced on audit results and recommendations from the Quantities. Personal Hygiene Audits will be on an ongoing basis. Audits will be on an ongoing basis. Audits will done on at least 3 residents persults will be reviewed by the and/or Administrator and give appropriate Nurse Manager for up. Upon completion of reviews/a corrective actions, if applicable implemented immediately. Accorrective actions will be provided as of from the reviews. Failure to acceducated protocols will result corrective counseling. The results of monitoring of the corrective actions (track, trend analysis) will be reported to the facility QA Committee monthly months. Upon this review, systevisions and/or staff education be implemented if indicated viprescribed corrective action pl	and/or 3 t udits d based A e done ill be er week Audit DON n to the er follow udits, e will be dditional derived dhere to in e and e for 6 tem n will a a		

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245304	B. WING	·	· · · · · · · · · · · · · · · · · · ·	11/0	08/2013
	PROVIDER OR SUPPLIER			30	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NORTH DOW STREET ANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F-353	Health Facility Cor 10/10/2013 with the alleged that the fact Staff to monitor an residents [R47]. "concerning F-B's during the survey: On 9/21/13 F-B ind R47 had long dirty had said she would complaint written to On 9/29/13 F-B do nursing indicated the staff to meet the nemenory care unit in pull them [nursing the NH [nursing had 12:00 noon on 9/20] residents waiting for cart had been in the staff members help table, so the food wuntil 12:30 p.m. Or been with R47 all of p.m., and that R47 brief changed this did change the pact in the brief. F-B reat which time the Elemployees were querning what to do The licensed social interviewed on 11/6.	omplaint with the Office of inplaints (OHFC) dated e complaint as written, "It is cility did not provide adequate d safety and hygiene of the The following was found complaint on investigation dicated residents other than fingernails and that the nurse d take care of it according to by F-B and given to the facility cumented the director of here should be a minimum of 3 eds of the residents on the but the DON said, "We need to assistants] for other areas of ome]." F-B stated that at 19/13 she was in the unit with 16 or their meals as the food tray the dining room. There were two ping another resident get to the was not served to the residents in 9/30/13 F-B stated she had day from 10:15 a.m. to 4:30 had not had their incontinence entire time and when the staff d it had some bowel movement ported this incident to the DON DON said the long time uitting and new staff are		353	Facility-DON-and-Administrator-will responsible for maintaining compliance. The facility alleges that it will be in substantial compliance with the standard indicated by 12/18/13.		12/18/13

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245304	B. WING		<u> </u>	111	/08/2013 (
	PROVIDER OR SUPPLIER CARE CENTER			30	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NORTH DOW STREET ANNON FALLS, MN 55009			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F-353-	-Continued-From-pa		F-3	353				
	R47 and had a coup resolve the concern concerns voiced by	dequate cares being done for ple meetings with F-B to as. LSW stated she had had several other families related d cares not getting done for						
	11/8/13 at 11:00 a.m required a minimum assistants on days a needs of the resider safety. CM-B stated the unmet cares the nurses were not alw CM-B said that the for bathing may not one staff on that day need assistance to be felt that the number	er (CM)-B was interviewed on n. She indicated the unit in staffing level of 2 nursing and evening to meet the ints and provide for their id it had been "Awful" due to all at residents don 't get and that ways available to help either, residents who need two staffinget a bath as there is only y. Also the residents who eat may have to wait long to assisted. CM-B stated she of falls have increased and because of the low staffing on						
	as they were afraid against, so date and included) said that the is short of staff they Memory care unit staffing and the staff that they don't need residents as it is low frequently that staff care unit and reside. The administrator are interviewed on 11/8/	equested not to be identified of being fired or retaliated I time of interview was not hey had been told if the floor are to pull one from the norting the memory care f on the memory care are told d to do bathing or showers for priority. E-A said this occurs is pulled from the Memory nt don't receive baths often. Indicator of nursing were 13 at 2:30 p.m. They both lentified the same concern						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	(X3) DATE SURVEY COMPLETED		
ļ.	•	245304	B. WING		11/08/2013
NAME OF I	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
411051.0	OADE OFNED		3	00 NORTH DOW STREET	
ANGELS	CARE CENTER			CANNON FALLS, MN 55009	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F-353-	-Continued-From pa	ge 38	F 353		
	that it was also disc Assessment and As director of nursing i during meals and g	the facility. They both said cussed at the Quality ssurance Committee. The ndicated they had identified etting residents up in the a.m. was the most difficult to get			
F 371	483.35(i) FOOD PF	•	F 371	Fans were both cleaned and a sche	dule
SS=F		SERVE - SANITARY	1 0/1	was put in place to ensure they are	1
00-1	OTOTICE THE THE	SERVE SAME		cleaned monthly and as needed. Th	1 3
	The facility must -			policy and procedure for sanitary ki	
		m sources approved or			l l
	considered satisfac	tory by Federal, State or local		conditions was reviewed and updat	ea.
	authorities; and				
		distribute and serve food		All dietary staff were re-educated o	n
	under sanitary cond	ditions		proper food handling practices,	1
				equipment cleaning and proper	(
	•			dishwasher temperatures and	
	•			procedures if temperatures are not	met
				as noted in the deficiencies on 11/1	
	This REQUIREMEN	NT is not met as evidenced		do no tod in tine donoi on 124, 2	
	by:	The flot met de evidenced		The Dietary Director will do audits 2	,
		ion, interview, and document		· ·	-
		ailed to maintain a sanitary		times a week x 1 month on proper	
		ent the spread of food borne		sanitary procedures. If compliance	
		ed food handling practices,		met, audits will be reduced to 1x pe	r
		, and sanitizing, drying and		week for 3 months or per	.]
		or resident food use. This had		recommendation of the QA Commi	ltee.
		ct 57 of 57 residents in the		Upon completion of reviews/audits	.
		n provided food prepared and			
ł	distributed from the	тасшту киспен.		corrective actions, if applicable, will	
.	Findings include: D	uring initial tour of kitchen on		completed immediately. Additiona	
ŀ		n., with dietary director		education will be provided as derive	l I
		ed a fan attached to wall with a		from the audits. Failure to adhere t	.o]
		p and was blowing directly	,	educated protocols will result in	
ĺ		Also there had been a stand		corrective counseling.	
ĺ					1

FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER ANGELS CARE CENTER CANNON FALLS, IM 55009 PREFIX GACH DEFICIENCY MUST REPRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 371 Continued From page 39 fan with a layer of dust build up sitting directly beside clean dishes. Sanitation of dishes was compromised due to dishwasher temperature had not reached the range of 120 degrees Fahrenheit. CH-C pushed the load of dishes and verified with surveyor at the time the temperature of wash cycle had reached 115 degrees Fahrenheit. CH-C pushed the load of dishes out of dishwasher and proceeded to start another load of dishes and again verified with surveyor at the time the temperature on 11/6/13, at 9:32 a.m., clearly director stated she would expect staff to stop washing dishes in the dishwasher in the water had not reached appropriate temperature, use three compartment sink instead of dish washer to sanitize dishes and staff is to notify her that the dishwasher was not working and she would call ECO Lab Company immediately. Document review of facility Cleaning Dishes/Dish Machine dated 2010, read "Policy: All flatware, serving dishes, and cookware will be washed, rinsed, and sanitize dishes, and coloware will be washed, rinsed, and sanitize date read vuse. Bish		FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
ANGELS CARE CENTER ANGELS CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 371 Continued From page 39 fan with a layer of dust build up sitting directly beside clean dishes. Sanitation of dishes was compromised due to dishwasher temperature had not reached the range of 120 degrees Fahrenheit. During observation on 11/6/13, at 9:18 a.m., cook helper (CH)-C had been observed washing a load of dishes and verified with surveyor at the time the temperature of wash cycle had reached 115 degrees Fahrenheit. CH-C pushed the load of dishes and verified with surveyor at the time the temperature of wash cycle had reached 115 degrees Fahrenheit. During interview on 11/6/13, at 9:32 a.m., dietary director stated she would expect staff to stop washing dishes in the dishwasher if the water had not reached appropriate temperature, use three compartment sink instead of dish washer to sanitize dishes and typic to stop washing dishes in the dishwasher if the water had not reached appropriate temperature, use three compartment sink instead of dish washer to sanitize dishes and typic to stop washing dishes in the dishwasher if the water had not reached appropriate temperature, use three compartment sink instead of dish washer to sanitize dishes and typic to stop washing dishes in the dishwasher if the water had not reached appropriate temperature as to dishes and salities to only reached 110 degrees Fahrenheit, not 120 degrees Fahrenheit as required to sanitize the dishes. Dietary director washed a load of dishes at this time and verified the dishwasher remperature had only reached 110 degrees Fahrenheit, not 120 degrees Fahrenheit as required to sanitize the dishes. Dietary director then said she would call ECO Lab Company immediately. Document review of facility Cleaning Dishes/Dish Machine dated 2010, read "Policy: All Illalware, serving dishes, and cookware will be washed, inseed, and sanitized and reach use. Dish			245304	B. WING _		11/	
CA1 D SUMMARY STATEMENT OF DEFICIENCES PROMISER'S PLANO CORRECTION (SEACH DEFICIENCY MUST BE RECEIVED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRETX TAG TAG CROSS-REFERNCED TO THE APPROPRIATE COMMITTED TO THE TOTAL THE APPROPRIATE CROSS-REFERNCED TO THE APPROPRIATE COMMITTED TO THE APPROPRIATE CROSS-REFERNCED TO THE APPROPRIATE COMMITTED TO THE APPROPRIATE CROSS-REFERNCED TO THE APPROPRIATE COMMITTED TO THE A	İ				300 NORTH DOW STREET		
fan with a layer of dust build up sitting directly beside clean dishes. Sanitation of dishes was compromised due to dishwasher temperature had not reached the range of 120 degrees Fahrenheit. During observation on 11/6/13, at 9:18 a.m., cook helper (CH)-C had been observed washing a load of dishes and verified with surveyor at the time the temperature of wash cycle had reached 115 degrees Fahrenheit. CH-C pushed the load of dishes out of dishwasher and proceeded to start another load of dishes and again verified with surveyor at the time the temperature of wash cycle had reached 111 degrees Fahrenheit. During interview on 11/6/13, at 9:32 a.m., dietary director stated she would expect staff to stop washing dishes in the dishwasher if the water had not reached appropriate temperature, use three compartment sink instead of dish washer to sanitize dishes and staff is to notify her that the dishwasher was not working and she would call ECO lab company. Dietary director washed a load of dishes at this time and verified the dishwasher temperature had only reached 110 degrees Fahrenheit, not 120 degrees Fahrenheit as required to sanitize the dishes. Dietary director then said she would call ECO Lab Company immediately. Document review of facility Cleaning Dishes/Dish Machine dated 2010, read "Policy: All flatware, serving dishes, and cookware will be washed, rinsed, and sanitized after each use. Dish	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP	OULD BE	
fan with a layer of dust build up sitting directly beside clean dishes. Sanitation of dishes was compromised due to dishwasher temperature had not reached the range of 120 degrees Fahrenheit. During observation on 11/6/13, at 9:18 a.m., cook helper (CH)-C had been observed washing a load of dishes and verified with surveyor at the time the temperature of wash cycle had reached 115 degrees Fahrenheit. CH-C pushed the load of dishes out of dishwasher and proceeded to start another load of dishes and again verified with surveyor at the time the temperature of wash cycle had reached 111 degrees Fahrenheit. During interview on 11/6/13, at 9:32 a.m., dietary director stated she would expect staff to stop washing dishes in the dishwasher if the water had not reached appropriate temperature, use three compartment sink instead of dish washer to sanitize dishes and staff is to notify her that the dishwasher was not working and she would call ECO lab company. Dietary director washed a load of dishes at this time and verified the dishwasher temperature had only reached 110 degrees Fahrenheit, not 120 degrees Fahrenheit as required to sanitize the dishes. Dietary director then said she would call ECO Lab Company immediately. Document review of facility Cleaning Dishes/Dish Machine dated 2010, read "Policy: All flatware, serving dishes, and cookware will be washed, rinsed, and sanitized after each use. Dish	F 371	Continued From pa	ge 39	F 37	71 The results of manitoring of th	;	
Machines will be checked prior to meals to assure proper functioning and appropriate		fan with a layer of dishes dishwasher temperarange of 120 degree During observation helper (CH)-C had to f dishes and verification the temperature of with dishes out of dishwasher load of dishwasher load of dishwasher load of dishwashing dishes in the tracked appropriate dishwasher was not ECO lab company. I load of dishes and dishwasher was not ECO lab company. I load of dishes at this dishwasher temperate degrees Fahrenheit, as required to sanitize then said she would immediately. Document review of Machine dated 2010 serving dishes, and rinsed, and sanitized Machines will be cheeped.	was compromised due to ature had not reached the es Fahrenheit. on 11/6/13, at 9:18 a.m., cook been observed washing a load ad with surveyor at the time wash cycle had reached 115. CH-C pushed the load of asher and proceeded to start es and again verified with the temperature of wash 11 degrees Fahrenheit. 11/6/13, at 9:32 a.m., dietary would expect staff to stop he dishwasher if the water had riate temperature, use three estead of dish washer to staff is to notify her that the working and she would call Dietary director washed a stime and verified the ature had only reached 110 not 120 degrees Fahrenheit be the dishes. Dietary director call ECO Lab Company facility Cleaning Dishes/Dish of the reach use. Dish ecked prior to meals to	F_37	corrective actions (track, trend analysis) will be reported to the Committee. Upon this review, revisions and/or staff education implemented if indicated via a corrective action plan. Facility Dietary Director will be responsible for maintaining corrective action plan. The facility alleges that it will be substantial compliance with the	and e QA system n will be prescribed mpliance.	12/18//

PRINTED: 12/11/2013 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
	*#***	245304	B. WING		11	11/08/2013	
	PROVIDER OR SUPPLIER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP (300 NORTH DOW STREET CANNON FALLS, MN 55009	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F-37-1-	Procedure: Prior to verification of prope function is made. Verification of product for the shift	use, run the machine until or temperatures and machine erify the soap and rinse d and have enough cleaning	F-37	71			
	During the taking of 11/7/13, at 11:05 a.r holding utensils in hagainst uniform/apron a towel in front ohad put thermomete temperature and hathermometer prior to	food temperatures on m., cook (C)-A had been ands and held utensils up on before laying them down f steam table containers. C-A er in chicken to check d not cleaned the busing it. C-A had gloves on door handle to open door of					
	closet, grabbed a wand proceeded to us thermometer between temperatures. While in steam table contar observed leaning ovutensils with apron. On 11/7/13, at 11:19 observed to grab the holder which had just temperatures from the placed the un-cleaned to check temperature cleaned the thermore pudding that was to During meal service 11:29 a.m., dietary dup lettuce and tomat	ipe with same pair of gloves se the wipe to clean en checking different foods at taking the food temperatures inners cook-A had been er utensils and touching a.m., CH-B had been ermometer out of pencil st been used to check food he steam table by C-A and ed thermometer into pudding e. CH-C verified she had not neter prior to putting in the be served to the resident. observation on 11/7/13, at irector was observed picking toes out of containers with					
; ;	soiled gloved hands with the same pair o handles of a drawer	and placing them on a plate f gloves on that had touched					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245304	B. WING_		11/08/2013	
1	PROVIDER OR SUPPLIER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLÉTION	
F 371	Continued From pa	ge 41	F_37	71		
F 373 SS=D	dietary director veri and tomatoes out of pair of soiled gloved drawer and refriger During interview on director stated she utensils with uniforn before use and not items and expected soiled. Document review of with Food and Use read "Procedure: (Iike hands. They ge contaminated surfate be changed." 483.35(h) FEEDING TRAINING/SUPER A facility may use and defined in §488.30 of assistant has succes State-approved traitequirements of §48 residents; and the use consistent with State A feeding assistant supervision of a reconsistent with state A feeding assistant supervisory nurse for system. A facility must ensured	ified they had grabbed lettuce of food containers with same is that had touched handle of ator with. 11/7/13, at 1:55 p.m., dietary expected staff to not touch m, should wash thermometer store thermometer with dirty digloves to be changed when of facility Bare Hand Contact of Plastic Gloves dated 2010, and a certain the gloves are just at soiled. Anytime a certain the gloves must a certain the gloves must are soiled. Anytime a certain the gloves must are for this chapter, if the feeding assistant, as a lof this chapter, if the feeding assistant is the gloves that meets the and a contain the gloves must work under the gistered nurse (RN) or licensed N). In the gloves dated 2010, and the gloves must work under the	F 37	Residents R5, R7, and R80 have	gers to late for a lat	
		re that a feeding assistant s who have no complicated		The Director of Nursing, Nurse Managers and Dietary Manage	r will	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		E CONSTRUCTION		E SURVEY PLETED
		245304	B. WING			11/	08/2013
NAME OF	PROVIDER OR SUPPLIER		<u>' </u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE		,,,,,
ANCELS	CARE CENTER]	30	00 NORTH DOW STREET		
ANGELS	CARE CENTER]	C	ANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
					implement corrective actions for	all	
F-37-3-	-Continued-From-pa	age-42	F-3		residents potentially affected by		
				- 1	practice including: A written	•	
		ng problems include, but are		- 1	procedure which includes the		
		ulty swallowing, recurrent lung be or parenteral/IV feedings.		- 1	procedure to be used for new		
	aspirations, and tu	be of paremeranty recaings.		- 1	admissions; the procedure used	to	
		ase resident selection on the			clinically assess residents and	;	
		essment and the resident's			•	DEA	
	latest assessment	and plan of care.		- 1	determine appropriateness for a		
	NOTE: One of the	specific features of the		- 1	to assist; and the method used for		Î
		nent for this tag is that paid		- 1	identifying which residents can a	ina i	
		must complete a training		ı	cannot be assisted by a Feeding	1	
		ollowing minimum content as		1	Assistant.	:	
	specified at §483.1	อบ: d training course for paid			•	!	
		must include, at a minimum, 8		1	Residents being assisted by a Fee	-	
	hours of training in				Assistant will be reviewed at wee	ekly ·	7"
•	Feeding technic				IDT meetings and with any signif	icant	
·		feeding and hydration.			change in condition.		
		and interpersonal skills. conses to resident behavior.					
		rgency procedures, including		H	Nursing and dietary staff were		
	the Heimlich mane			- 1	educated on 11/27/13 on the rev	vised	
	Infection contro	•		1	policy and procedure for Paid Fe		
	Resident rights.		,	1.	Assistants.		
		anges in residents that are eir normal behavior and the				l	
		rting those changes to the			Random audits will be done wee	kly	
	supervisory nurse.	•		- 1	for 3 months by DON and/or	y	
				i	•	nco	
		tain a record of all individuals		- 1	Administrator to ensure complia		
		as feeding assistants, who completed the training course			with weekly IDT reviews and cha	nges	
	for paid feeding as:						
			•				
	This REQUIREME	NT is not met as evidenced					

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245304	B. WING	;		11/	/08/2013 (
	PROVIDER OR SUPPLIER CARE CENTER			3	STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) - COMPLETION DATE
	Based on observat review, the facility fa (R5, R7, and R80) reating, were compresafely fed by a paid (non-nursing trained residents with eating Findings include: R5, R7 and R80 we however, R5, R7 and swallowing difficultie pneumonia and woubeen safely assisted PFA lacks the training with swallowing difficulty swallowing difficulty swallowing Review of the quarted dated 10/14/13; ider cognitive impairment eating, had no swallowed mechanical soft texts. R5's care plan dated resident had received mechanical soft texts. R5's care plan dated resident had received required assist at mechanical soft texts.	ion, interview and document ailed to ensure 3 of 3 residents reviewed for assistance with ehensively assessed to be feeding assistant (PFA) of person used to assist a person used to assist a person used to assist a person used to assist a person used to assist a person used to assist a person used to assist a person used to assist residents and not have qualified to have a to eat using a PFA as the ang and skill to assist residents culties safely. In at included dysphagia and a person used to assist ance with a person used to eat using a person used to eat using a person used to eat using a person used to eat using a person used to have a to eat using a person used to have a person used to have a person used to be used to ensure a person used to eat u	F	3731	in condition and appropriateness residents currently being assisted with eating by feeding assistants. A review of the audit results by the Medical Director and QA Commitwill be done for 6 months. Audit frequency will be reduced based on compliance and recommendations from the QA Committee. Facility Director of Nursing and Administrator will be responsible maintaining compliance. The facility alleges that it will be substantial compliance with the standard indicated by 12/18/13.	he ttee	12/18/13

FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	1 ' '	ING	COMPLETED
*, 4	i sa sa sa sa sa sa sa sa sa sa sa sa sa	245304	B. WING.		11/08/2013
	PROVIDER OR SUPPLIER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COI 300 NORTH DOW STREET CANNON FALLS, MN 55009	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
F-373	esophageal reflux a pneumonitis due to Review of the annuidentified R7 had se required assistance swallowing difficultialtered diet. The cu 9/6/13 identified a national R7's care plan date swallowing difficultial malnutrition and deintervention include unable, provide medicare plan did not ide to be fed by a PFA. interdisciplinary teal assist R7 to eat every swallowing problem. R80's diagnoses inconsused, and esophate R80's diagnoses inconsused, and esophate R80's diagnoses inconsused, and esophate R80's care plan date at thick liquids. R80's care plan date resident had been unrequired assist with time and between mot identify if the resident for the resident f	hat included dementia and and had a history of inhalation of food or vomitus. al MDS dated 10/3/13; evere cognitive impairment, with eating, had no es, and was on a mechanically rrent physician order dated nechanical soft texture die. d 9/24/13 identified es, aspiration pneumonia, nydration. The care plan d assist to eat if resident chanically altered diet. The entify if the resident was safe The recommendation of the m (IDT) allowed PFAs to in though R7 had documented and aspiration pneumonia.	F-3	73	

	TEMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245304	B. WING	;		11	/08/2013	
NAME OF PROVIDER OR SUPPLIER ANGELS CARE CENTER			;	STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 373	Continued From p	nage 45	E -	3.7.3			س	
	team (IDT) allowe	nd PFAs to assist R80 to eat had documented swallowing	F\	o. <i>I</i> _o				
	observed in the di	12 p.m., the hospice aide was ning room feeding R80: R80 owing or eating difficulties.						
	of nursing (DON) completed by the certified dietary m MDS questions, re therapy recomme determine if a resi	on 11/05/13, at 4:00 p.m. director reported PFA assessment is registered dietitian (RD) and anager (CDM.) The DON stated esident diagnoses, and speech and the could be fed by PFA and on the comments section on the						
	verified R5, R7, at DON stated the faresidents had been based on the RD, (RN) assessment summary note wo medical record to DON verified resident and history of asp by PFA. The DON comprehensive ID	T assessment had been found , R7, and R80 could have been						
·	dated 2006, read, those residents wl problems. Complie but are not limited	lity policy Feeding Assistance "A feeding assistant feeds only no have no complicated eating cated eating problems include, to, difficulty swallowing and irations." The policy further						

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		AND HUMAN SERVICES		O		APPROVED
STATEMENT	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		245304	B. WING		11/0	08/2013
NAME OF	PROVIDER OR SUPPLIER		<u>'</u>	STREET ADDRESS, CITY, STATE, ZIP CODE		
ANGELS	CARE CENTER			BOO NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE
F-373-	Continued From pa	ae 46	F 373	·		
	indicated the facility on the resident's lat and the RN assess condition. 483.60(c) DRUG R IRREGULAR, ACT The drug regimen or reviewed at least or pharmacist. The pharmacist muthe attending physic	would base resident selection test assessment, plan of care ment of the resident's current EGIMEN REVIEW, REPORT	F 428	Residents R56 and R8 were reassesse	tions nxiety vere ed for tions s and	
	by: Based on interview failed to ensure the identified irregularitidirector of nursing a non-pharmacologic administration of PF residents (R8) and disturbance for 1 of unnecessary medic Findings include: R8 received as need	or and record review the facility consultant pharmacist ies and reported them to the and physician for use of all interventions before the RN pain medications for 1 of 5 failed to assess for sleep 5 residents (R8) reviewed for eations.		The Consultant Pharmacist was reeducated on facility policy and proce for use of non-pharmacological interventions prior to giving PRN me pain, anxiety or sleep. The Consultant Pharmacist was infor of the process to be used to prompt nursing staff to offer non-pharmacol interventions on the EMAR. A promappear in the EMAR that will remind to offer non-pharmacological intervebefore giving PRN pain, sleep or antianxiety meds. There will be a list of options that can be utilized.	ds for med ogical pt will nurses entions	

non-pharmacological measures. R8 received antidepressant medication (Trazodone) for

insomnia without being assessed for sleep

options that can be utilized.

Nursing staff was educated on 11/27/13 on

the policy and procedure for offering non-

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245304	B. WING		11/0)8/2013 ()	
	PROVIDER OR SUPPLIER CARE CENTER			30	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NORTH DOW STREET ANNON FALLS, MN 55009	- V	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		BE	(X5) COMPLETION DATE	
					pharmacological interventions and		·
F-428-	-Continued-From-pa	ae-47	F-4	28			
-	quality.	3 - · · ·			effectiveness.		
	diagnoses that includementia, osteoarth chronic pain. The q (MDS) dated 8/20/1 sleeping, received s received PRN medinon-medication interpain and pain intensinterview of mental of 15 on the MDS a cognitive impairmer During review of R8 dated 10/30/13, rev 5milligrams (mg) exbreakthrough pain,	erventions for pain, frequent sity score of 10. R8's brief status (BIMS) had been 9 out nd indicated moderate nt. B's current physician orders realed an order for oxycodone very six hours PRN for Tylenol 650 mg every four and Trazodone 50 mg at			The Director of Nursing and/or design will implement the same policy and procedure identified above to be use all residents regarding the use of nor pharmacological interventions. All residents will be reviewed at care conferences or with significant changeresident-specific non-pharmacological interventions. Medical Records or designee will be responsible for inputting non-pharmacological prompt in PCC for a admissions. The Director of Nursing and/or designee will implement measures to ensure this practice does not recur, including	d for ges for al II new thee	
·	9/24/13, identified p and directed nurses	s's care plan review date roblem of impaired comfort s to offer non-med as warm packs, cool packs,			Review and revision of the policy and procedure for Non-Pharmacological Interventions.	_	
	repositioning, distra for interrupted sleep encourage activities limit caffeine intake quiet sleep environr	ction techniques PRN. At risk and directed staff to and activeness during day, after three p.m. and provide ment. Diagnosis of insomnia			A review of the revised policies by the Medical Director will be conducted to determine if policy meets current standards of practice.		
	During review of R8 record and progress documentation shee noted from the date	essant medication for sleep ssed on the care plan. Is medication administration so notes of PRN medication ets the following had been so of 10/4/13 through 10/31/13: d a total of four doses of PRN			The Director of Nursing and/or design will monitor the corrective actions to the ensure the effectiveness of these actions to the completing audits on at least 3 relevery week to ensure non-pharmacconterventions are being utilized and	o tions sidents	

		AND HUMAN SERVICES					APPROVED	
		& MEDICAID SERVICES			O	<u>ив по.</u>	0938-0391	7
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
. 4	And the second second	245304	B. WING		• 11/0	08/2013	, I. .	
NAME OF	PROVIDER OR SUPPLIER		<u>' </u>	S.	TREET ADDRESS, CITY, STATE, ZIP CODE		 .	ı
ANOFIC	OADE OFFICE			30	00 NORTH DOW STREET			
ANGELS	S CARE CENTER			С	ANNON FALLS, MN 55009			
(X4) ID PREFİX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ζ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	,
F 428	Continued From pa	ao 48		20				_
1 420			F 4:	28	Upon completion of reviews/audits,			╁
	Tylenol with no doc	umentation of al interventions attempted			corrective actions, if applicable will be	oe .		
		on and two doses of PRN			completed immediately. Additional			
	oxycodone with no			ı	education will be provided as derived	d from		
		al interventions attempted		1	the reviews. Failure to adhere to edi	ucated		
		on for one of two doses.		1	protocols will result in corrective	acatea		
		tes of 11/1/13 through		1	counseling.			l
	11/7/13: R8 had rec	eived a total of two doses of						
	PRN Tylenol with no				The results of monitoring of the corre	ective		l
		al interventions attempted			actions (track, trend and analysis) wil	ll ho		ı
		on for one of two doses and			reported to the facility QA Committe			l
	four doses of PRN of			1	monthly for 6 months. Upon this rev			l
	documentation of no	on-phannacological oted for three of four doses.		- 1	system revisions and/or staff educati			l
	interventions attemp	oted for timee of four doses.			be implemented if indicated via a	OH WIII		l
	During interview on	11/7/13, at 8:38 a.m.,	1		prescribed corrective action plan.		Ì	
	registered nurse (R	N)-C stated should monitor			prescribed corrective action plan.			•
		iagnosis of insomnia and			Fraguency of the audita will be used as	,		
		is started for sleep. RN-C			Frequency of the audits will be reduc	ea		
		onitoring had been done for		-	based on compliance and			l
	R8.				recommendations from the QA Comr	nittee.		
	During interview on	11/8/13, at 10:38 a.m., RN-C			Facility DON will be responsible for			
	stated should offer r	repositioning at minimum for			maintaining compliance.			
	non-pharmacologica	al intervention prior to giving						
		n. RN-C verified not charting	}	i	The facility alleges that it will be in		1.1/12	
	non-pharmacologica	al interventions.			substantial compliance by 12/18/13.		12/18/13	١
	During interview on	11/8/13, at 11:07 a.m.,			, , ,			
		tated she expected sleep						l
	assessment to be de							ĺ
1		and non-pharmacological						
	interventions to be t	ried prior to administering	ĺ	Ì				
	PRN pain medicatio	n and to document the						
	non-pharmacologica	al interventions.						
	During interview on	11/8/13, at 1:03 p.m., facility			•			
	consulting pharmaci	ist stated expected sleep to						ĺ
	be done if resident r	not able to sleep and when						l

		AND HUMAN SERVICES & MEDICAID SERVICES				RM APPROVED 10. 0938-0391		
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245304	B. WING			11/08/2013		
NAME OF PROVIDER OR SUPPLIER ANGELS CARE CENTER				30	TREET ADDRESS, CITY, STATE, ZIP CODE DO NORTH DOW STREET ANNON FALLS, MN 55009			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
==F-428	-Continued-From-pa	ge-49	 F-Z	128			-	
20	reviewing charts roo	utinely does not look for all interventions tried before		120				
-	Regimen Review da Procedure: 3. Facili review each resider directly from the res with Interdisciplinan	f facility policy Medication ated 12/1/07, read " ty should independently tt's medication regimen ident's medical chart and y Care Team members, sible Party, as needed."						
F 431 SS=D	483.60(b), (d), (e) D		F 4	131	The facility procedure for Disposal/Destruction of Controlled			
	a licensed pharmac of records of receip controlled drugs in a accurate reconciliat records are in order	aploy or obtain the services of ist who establishes a system that and disposition of all sufficient detail to enable and ion; and determines that drugh and that an account of all maintained and periodically	·	·	Medications was reviewed and revised to include proper destruction of used transdermal patches. The updated procedure was reviewed with licensed nursing staff and TMA's on 11/27/13. A copy of the procedure was placed at each nursing station for reference.			
	labeled in accordant professional principal appropriate accessor		-		The Nurse Managers will do weekly aud on disposal of transdermal medications for 3 months. Results will be given to the DON weekly to review.			
	facility must store al locked compartmen	State and Federal laws, the I drugs and biologicals in ts under proper temperature only authorized personnel to keys.			Upon completion of reviews/audits, corrective actions, if indicated, will be completed immediately. Additional education will be provided as derived from the reviews/audits. Failure to adhere to educated protocols will result	in		

The facility must provide separately locked, permanently affixed compartments for storage of

corrective action.

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245304 B. WING 11/08/2013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 300 NORTH DOW STREET ANGELS CARE CENTER CANNON FALLS, MN 55009 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) The Medical Director and QA Committee -F-431-Continued-From-page-50-E-431 will review the revised procedure and controlled drugs listed in Schedule II of the recommendations from the Committee Comprehensive Drug Abuse Prevention and will be implemented. Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the The Director of Nursing or/designee will quantity stored is minimal and a missing dose can monitor the corrective actions to ensure be readily detected. the effectiveness of these actions. including compliance with controlled medication destruction/disposal. This REQUIREMENT is not met as evidenced by: The results of monitoring of the corrective Based on observation; interview and actions (track, trend and analysis) will be documentation review, the facility failed to reported to the facility QA Committee document destruction of fentanyl patches (a monthly for 6 months. Upon this review, narcotic used for moderate to severe pain) for 3 system revisions and/or staff education of 3 medication rooms. This practice could encourage diversion of pain medications by staff. will be implemented if indicated via a residents and/or visitors. prescribed corrective action plan. Findings include: During medication storage tour on 11/8/13, at 8:40 a.m. licensed practical nurse If there is compliance with the procedure (LPN)-C indicated the process for destruction of after 3 months, audits will be reduced per fentanyl patches had been to fold the patch up recommendation of the QA Committee. then placed into the sharps container (A sharps container is a term for a specially-made container Facility Director of Nursing will be that is predominantly used for medical needles and any other sharp medical instruments. It is responsible for maintaining compliance. also a secured enclosed system that deters

disposal of the patch.

removal of content easily or safely.) LPN-C

confirmed fentanyl patch destruction had not

During interview on 11/8/13, at 12:51 p.m. the Director of Nursing (DON) indicated the process of disposal of fentanyl patches included fold the

registered nurse (RN)-C verified the used fentanyl patches were placed in the sharps containers but indicated they had not had another nurse sign

included co-signatures of another nurse.

During interview on 11/8/13, at 12:45 p.m.

The facility alleges that it will be in

indicated by 12/18/13.

substantial compliance with the standard

12/18/13

		AND HUMAN SERVICES & MEDICAID SERVICES	•		·		APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION .	(X3) DATE SURVEY COMPLETED	
	. •	. 245304	B. WING			11/08/2013	
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		. 1
ANGELS	CARE CENTER				00 NORTH DOW STREET ANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
—F-431-	-Continued-Erom-pa	ge-51	 =-4	131			
	patch over and place sharps container are the destruction. The expectation would be the disposal of the fiverified the fentanylidentified not sure if performed. Request destruction policy herovided.	ced the used patch in the ad ideally two staff would initial a DON confirmed the be that two staff would cosign rentanyl patch. The DON patch was a narcotic but that process was being ted a copy of fentanyl patch owever, none had been					
F 441 SS=D	facility consultant pl practice " would ha a form that the fenta once removed from 483.65 INFECTION SPREAD, LINENS The facility must es Infection Control Pr safe, sanitary and of to help prevent the	tablish and maintain an ogram designed to provide a omfortable environment and development and transmission	F 4	141	The policy and procedure for clear glucometer was reviewed and upowill be available at each nursing unreference. Licensed nursing staff was educated 11/27/13 on the policy and procedure.	dated. It nit as a	
	Program under whice (1) Investigates, continuous in the facility; (2) Decides what proshould be applied to (3) Maintains a reconstructions related to in (b) Preventing Spreaction (1) When the Infection (1) Investigates (1)	I Program tablish an Infection Control ch it - ntrols, and prevents infections ocedures, such as isolation, o an individual resident; and ord of incidents and corrective fections.			cleaning the glucometer, which increturn demonstration. All pool staff and new employees trained during orientation. The Director of Nursing and/or Nu Managers will do audits 2 times as 1 month on cleaning of the glucom If compliance is met, audits will be reduced to 1x per week for 1 month monthly or per recommendation of OA Committee	will be rse week x neters. th, then	

QA Committee.

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING _ B. WING 245304 11/08/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET **ANGELS CARE CENTER** CANNON FALLS, MN 55009 SUMMARY STATEMENT OF DEFICIENCIES . PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) -Upon-completion-of-reviews/audits,-F-441-Continued From page 52 corrective actions, if applicable, will be prevent the spread of infection, the facility must completed immediately. Additional isolate the resident. education will be provided as derived (2) The facility must prohibit employees with a communicable disease or infected skin lesions from the audits. Failure to adhere to from direct contact with residents or their food, if educated protocols will result in corrective direct contact will transmit the disease. counseling. (3) The facility must require staff to wash their hands after each direct resident contact for which The results of monitoring of the corrective hand washing is indicated by accepted actions (track, trend and analysis) will be professional practice. reported to the QA Committee for 6 (c) Linens months. Upon this review, system Personnel must handle, store, process and revisions and/or staff education will be transport linens so as to prevent the spread of implemented if indicated via a prescribed infection. corrective action plan. Facility Director of Nursing will be This REQUIREMENT is not met as evidenced responsible for maintaining compliance. by: Based on observation, interview, and document The facility alleges that it will be in review, the facility failed to implement procedures substantial compliance with the standard to prevent the possible spread of blood borne infections during blood glucose monitoring indicated by 12/18/13. performed for 1 of 1 resident (R42) who had blood sugars readings taken with the use of a glucose machine. Findings include: R42 's glucometer had been sanitized with an antimicrobial agent but should have been sanitized with an agent that kills blood borne infections. Also the nurse had not used

gloves or a barrier when sanitizing a soiled glucometer and had been at risk to come in

R42 was observed to have blood drawn on 11/4/2013 at 11:45 a.m., for a blood glucose level test by licensed practical nurse (LPN)-D. LPN-D

contact with blood borne diseases.

	•	AND HUMAN SERVICES & MEDICAID SERVICES			OI		APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	PPLIER/CLIA (X2) MULTI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245304	B. WING			11/08/2013	
NAME OF PROVIDER OR SUPPLIER			· · · · · ·		TREET ADDRESS, CITY, STATE, ZIP CODE		
ANGELS	CARE CENTER			ľ	00 NORTH DOW STREET CANNON FALLS, MN 55009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F-441-	_Continued_From_pa	qe-53	F7	4 <u>4:1</u> :			
	was observed to rea drop of blood on i had rolled up in a great medication cart, LP wipes to wipe the great any barrier but used glucometer that had resident's blood. Of wiped, LPN-D immedication cart minute drying time of glucometer. The Material Safety identified the hand wipes. It has alcohologous interviewed regularity of glucom verified the staff short required gloves and PDI cleanser (alcohological).	emove the test strip which had that and disposed it by having love. Upon returning to the N-D used PDI Sani Hands lucometer but had not used the bare hands to wipe the discome in contact with the lonce the glucometer was ediately put the glucometer in and had not allowed the two to properly sanitize the discome the active ingredient. Data Sheet for PDI product wipes as antimicrobial alcoholoid as the active ingredient. Define products to use for the edit of the using the cleanser that was the most stringent. The old based) is not the one to be may not be educated well					
F 465	Disinfecting Blood On Health Services Inferwas provided by the wipes have a 2-min HBV, HBC, disease manufacture guidelian approved production disinfecting equipments.	ves must be worn per MSDS	F 4	165			
	• •			-			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

		AND HUMAN SERVICES				FORM APPROVED	
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				B NO. 0938-0391	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245304	B. WING _			11/08/2013	
NAME OF	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY	, STATE, ZIP CODE		
ANGELS	CARE CENTER			300 NORTH DOW STR			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S (EACH CORRECTED CROSS-REFEREI	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRI DEFICIENCY)		
F-465-	Continued From pa	no-5/		The wall behind the	e oven the oven was		
SS=C		L/SANITARY/COMFORTABL	F 46	cleaned. A policy v	vas put into place		
	E ENVIRON			including a general the kitchen enviror	cleaning schedule of ment.		
	sanitary, and comfo residents, staff and	·		build up, grease spo	s re-educated on ocedures including du ots and food build up iciencies on 11/13/13	·	
	by: Based on observati had not maintained a kitchen where food v	on and interview, the facility a sanitary environment in the was stored, cooked and esidents in the facility.			a week x1 month. If audits will be reduced	i	
	a.m., with dietary dir the wall in the kitche had dust build up, gr ovens had a visible I director stated the or month and between spills they should be During interview on director stated she h	kitchen on 11/4/13, at 9:10 ector, observation revealed n located behind the ovens rease spots and one of the ayer of food build up. Dietary vens get cleaned once a this cleaning if there are food cleaned immediately. 11/7/13, at 11:22 a.m., dietary ad no policy regarding the redule of kitchen environment ances, walls, etc.		completed immedia education will be profession to the audits. Fareducated protocols corrective counseling. The results of monital actions (track, trends reported to the QA months. Upon this revisions and/or statimplemented if indications (track) action place. Facility Dietary Directive action place.	f applicable, will be ately. Additional rovided as derived ilure to adhere to will result in ag. toring of the correctival and analysis) will be Committee for 6 review, system ff education will be cated via a prescribed in.		
				The facility alleges the substantial compliar indicated by 12/18/1	nce with the standard	12/18/13	

F5304023

Printed: 11/20/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING 01 - MAIN BUILDING 01

(X3) DATE SURVEY COMPLETED

245304

B. WING

11/05/2013

NAME OF PROVIDER OR SUPPLIER

ANGELS CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

300 NORTH DOW STREET CANNON FALLS, MN 55009

K 000

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE

K 000 INITIAL COMMENTS

FIRE SAFETY

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, Angels Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 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

By email to: Marian.Whitney@state.mn.us

Pocok 8 1-14-14



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.

Printed: 11/20/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NUMBER 1	DEMODEL PERMONIA		E CONSTRUCTION 01 - MAIN BUILDING	(X3) DATE SURVEY COMPLETED		
245304		B. WING	B. WING		11/05/2013	
NAME OF PROVIDER OR SUPPLIER ANGELS CARE CENTER	300 NC	DRESS, CITY, ST DRTH DOW DN FALLS, I				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY TAG REGULATORY OR LSC IDENTIFYING INFORM	full	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECT IVE ACTION SHOU ED TO THE APPRO FICIENCY)	JLD BE	(X5) COMPLETION DATE
K 000 Continued From page 1 THE PLAN OF CORRECTION FOR EA DEFICIENCY MUST INCLUDE ALL OF FOLLOWING INFORMATION: 1. A description of what has been, or will to correct the deficiency.	THE	K 000		27		
2. The actual, or proposed, completion of a superson and monitoring prevent a reoccurrence of the deficiency. This facility will be surveyed as two sepa buildings. Angels Care Center is a 1-stor building with no basement. The building constructed at 3 different times. The original building was constructed in 1977 and was determined to be of Type II(111) constructed to the Westhat was determined to be of Type II(111) construction. In 1985, another addition was added to the South Wing and was determined to Type II (111).	g to rate y was inal s ction. In est Wing)				4: 5:	
The building is fully sprinklered. The facilific alarm system with full corridor smoke detection and spaces open to the corridor monitored for automatic fire department notification. The facility has a capacity of 89 beds and census of 59 at the time of the survey. The requirement at 42 CFR, Subpart 483 NOT MET as evidenced by:	rs that is					
K 067: NFPA 101 LIFE SAFETY CODE STANDA	ARD	K 067			9	

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES	6	J.S.	Printed: 11/20/2 FORM APPROV	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED	
	245304	B. WING	44/05/0040		
NAME OF PROVIDER OR SUPPLIER	STRE	EET ADDRESS, CITY, STATE, ZIP CODE		11/05/2013	
ANGELS CARE CENTER	3	00 NORTH DOV ANNON FALLS	V STREET		
TAG REGULATORY OR I	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD RE COMPLETI	
K 067 Continued From pa SS=F		K 067	The facility had the fire/s	moke	
Heating, ventilating,	and air conditioning comp	oly	dampers tested by Canno	n Fire	
in accordance with t	of section 9.2 and are insta	alled	and Safety. The work was	S	
specifications. 19	.5.2.1, 9.2, NFPA 90A,		completed on 1/8/14.		
10.0.2.2	92		Ongoing compliance will be	ar	
*		1 1	ensured by having the dar	mners	
			added to our fire check lo	that is	
interview, that the faction in accordance in	cility's general ventilating a m (HVAC) was not ance with the LSC. Section	1	reviewed monthly. Facility maintenance director will be responsible for ensuring compliance.		
Findings include:			₹* :	: ::	
damper testing log for all of the fire/smoke d	en 12:45 PM and 2:45 PM nentation review of the fire the past 4 years revealed ampers have not been 4 years. Last documented		(m. 172).	1 2 2	
This deficient practice Facility Maintenance Deficiency discovery.	was confirmed by the Director (DR) at the time of			5	
TEAM COMPOSITION Gary Schroeder, Life S	N afety Code Spc.			ě	

SERVICE WORK ORDER

CANNON FIRE AND SAFETY
36960 COUNTY 57 BLVD.
DENNISON, MN 55018
(ph) 507-263-0243
cannonfireandsafety@gmail.com
license #TS675661

DATE: 12/30/13	CUSTOMER PO#	JOB COI	MPLETED YES 🔲 NO 🔳
LOCATION: Angels Car	B Center		
STREET ADDRESS: 3	00 Dow Street North	City: Cannon Falls	STATE: MN ZIP: 55009
WORK REQUESTED BY	2: Don Rapp	PH: 263-4658	EMAIL:
WORK PERFORMED:	Check the operation of the fire dam	pers per State Fire Marshal i	notice- Continued tracking 300 wing
damper power supply and c	ontrol circuit (which is branched to t	hree different loads). Verifie	d circuit loads to the damper control
	r circuit and magnetic door lock circ		
Since the 300 wing damper	control circuit is not a standard set-t	JP, circuit function from HVA	C unit conditions should be verified by
your HVAC contractor.			s and conducts should be verified by
			W-11
Will return to complete work.			
10:00- 1:15: 4 1/4 hours		<u></u>	
PARTS:			
Jan 79'	······································		400040
TECHNICAN SIGNATURE	CUSTOMER SIG	NATURE	12/30/13 DATE

- THIS IS NOT AN INVOICE

Cannon Fire & Safety is a Fehling Family Farm Inc. Company

SERVICE WORK ORDER

CANNON FIRE AND SAFETY
36960 COUNTY 57 BLVD.
DENNISON, MN 55018
(ph) 507-263-0243

cannonfireandsafety@gmail.com
license #TS675661

DATE: 12/27/13 CUST	OMER PO#	JOB CO	MPLETED YES 🗌 NO 🔳
LOCATION: Angels Care Center			
STREET ADDRESS: 300 Dow S	treet	CITY: Cannon Falls	STATE: MN ZIP: 55009
WORK REQUESTED BY: Don Re	арр	PH: 263-4658	EMAIL:
WORK PERFORMED: Check the	e operation of the fire dam	pers per State Fire Marshal	notice- Checked 300 wing dampers for
operation. Found several issues: Da	mpers are not connected	to the fire alarm system, the	circuit powering the dampers is not
fused properly and is also powering the			
open and communication cables are i			
splices (fire alarm, damper control, ele			
removing power at each damper. One			
Began tracking damper control circuit	through Junction boxes an	d HVAC relays to verify relay	contacts are closed to allow dampers
to function property.	· · · · · · · · · · · · · · · · · · ·		contacts are deser to allow dampers
Will return to complete work.			
8:15am- 11:15am: 3 hours			
PARTS:			78°
**************************************	- Walter Salari		- No.
			The state of the s
Sma (O)			
TECHNICAN SIGNATURE	CUSTOMER SIG	VATURE	<u>12/27/13</u> DATE

THIS IS NOT AN INVOICE

Cannon Fire & Safety is a Fehling Family Farm Inc. Company

SERVICE WORK ORDER

CANNON FIRE AND SAFETY
36960 COUNTY 57 BLVD.
DENNISON, MN 55018
(ph) 507-263-0243
cannonfireandsafety@gmail.com
license #TS675661

DATE: 12/26/13 C	USTOMER PO#	JOB CO	MPLETED YES NO
LOCATION: Angels Care Ce	nter		
STREET ADDRESS: 300 D	ow Street North	CITY: Cannon Falls	STATE: MN ZIP: 55009
WORK REQUESTED BY: D	on Rapp	PH: <u>263-4658</u>	EMAIL:
WORK PERFORMED: Che	k the operation of the fire da	mpers per Stat Fire Marshal n	otice- Checked operation of 100, 200,
and 400 wing dampers. All dam	per close when power is rem	oved at the damper. Verified o	sircuit integrity of all damper circuits to
			i. Discovered that the programming of
the fire alarm system had been a			
			wings- all dampers function properly.
Will return to work on the 300 wir	g dampers.		
8:30-11:45 & 12:30- 3:45: 6 1/i	2 hours		
PARTS:			
	ijelikova i jako kontrolikova		
TECHNICAN SIGNATION	_		12/26/13
TECHNICAN SIGNATURE	CUSTOMER S	GNATURE	DATE

THIS IS NOT AN INVOICE

Cannon Fire & Safety is a Fehling Family Farm Inc. Company

Printed: 11/20/2013 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

(X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES A. BUILDING 02 - 2007 CHAPEL ADDITION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION B. WING_ 245304 11/05/2013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 300 NORTH DOW STREET ANGELS CARE CENTER **CANNON FALLS, MN 55009** (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K 000 INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Angels Care Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. This facility was surveyed as two separate buildings. The Angels Care Center, 2007 addition is a 1-story building, with no basement. The 2007 addition was determined to be of Type V(111) construction. The 2007 addition is fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, that is monitored for automatic fire department notification. The facility has a capacity of 89 beds and had a census of 59 at time of the survey. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc. (X6) DATE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

(X2) MULTIPLE CONSTRUCTION

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.



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 6657

December 11, 2013

Ms. Kristina Umberger, Administrator Angels Care Center 300 North Dow Street Cannon Falls, Minnesota 55009

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5304023, H5304018

Dear Ms. Umberger:

The above facility was surveyed on November 4, 2013 through November 8, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5304018. that was found to be substantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

Angels Care Center December 11, 2013 Page 2

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

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

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 18 Wood Lake Drive Southeast Rochester, Minnesota 55904. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact GaryNederhoff at (507) 206-2731.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring P.O. Box 64900 St. Paul, Minnesota 55164-0900

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

Email: mark.meath@state.mn.us

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

5304s14lic.rtf

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		00758	B. WING		11/08	8/2013
NAME OF PE	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
ANGELS (CARE CENTER		H DOW STREE FALLS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTEN	TION*****				
	NH LICENSING CO	ORRECTION ORDER				
	144A.10, this correcting pursuant to a survey. found that the deficient herein are not correct not corrected shall be with a schedule of finithe Minnesota Depart. Determination of whe corrected requires correquirements of the runumber and MN Rule When a rule contains comply with any of the lack of compliance. Live-inspection with any result in the assessments of the runumber and many result in the assessments.	ther a violation has been				
	that may result from rorders provided that a	earing on any assessments non-compliance with these a written request is made to 15 days of receipt of a for non-compliance.				
	this Department's star and the following licer When corrections are date on the bottom of marked with "Laborate	7 and 8, 2013, surveyors of ff visited the above provider nsing orders were issued. completed, please sign and the first page in the line		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal softw Tag numbers have been assigned to Minnesota state statutes/rules for Nur Homes.		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Minnesota Department of Health

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	(
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00758	B. WING		11/08/201	13
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	NTE, ZIP CODE		
		300 NORT	H DOW STREE	ET .		
ANGELS	CARE CENTER	CANNON	FALLS, MN 55	009		
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2 000	Continued From page	e 1	2 000			
	make a copy of these original to the address. Minnesota Department 18 Wood Lake Drive structure c/o Gary Nederhoff, L 507-206-2731 Investigation/s of common completed and had be findings issued at Stat Rule 4658.0525 subp	orders and return the s below: nt of Health SE, Rochester, MN 55904.		The assigned tag number appears in far left column entitled "ID Prefix Tag The state statute/rule out of compliant listed in the "Summary Statement of Deficiencies" column and replaces the Comply" portion of the correction order This column also includes the findings which are in violation of the state state after the statement, "This Rule is not as evidence by." Following the survey findings are the Suggested Method of Correction and Time period for Correction	" ce is e "To er. s ute met ors stion. G OF	
2 565	MN Rule 4658.0405 S Plan of Care; Use	Subp. 3 Comprehensive	2 565			
		nprehensive plan of care ersonnel involved in the				
	by:	t is not met as evidenced n, interview and document ed to provide eating				

Minnesota Department of Health

STATE FORM 6899 ETLH11 If continuation sheet 2 of 50

Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00758	B. WING		11/	/08/2013	
NAME OF PRO	VIDER OR SUPPLIER		DDRESS, CITY, STA				
ANGELS CA	RE CENTER		TH DOW STREE FALLS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
a 3 s Fn Fdd a 8 ns Fnfn o Fsp Edcge Ehhklay	services. Findings include: R21 neals or snacks according and been admitted liagnoses that included liabetes, protein-calor admission. Minimum 18/29/13, indicated R2 nental status (BIMS) nevere cognitive imparts and intervention alteration per or consistency altered neals and intervention and review of Filated 10/24/13, indicated 10/24/13, indi	ed and care planned for 1 of ewed for nutritional had not been assisted with ording to R21's plan of care. ed on 8/22/13 with ed but not limited to rie malnutrition. R21's Data Set (MDS) dated 1 had a brief interview for score of five, which is airment. on dated 11/1/13, indicated: r cognitive changes, need d meats, one assist with ns: diet per physician sist to eat all meals. es dated 10/30/13, indicated aily between meals to R21's dietary progress note ated weight loss, ed diet, and meats are all snacks. R21 to be	2 565				

Minnesota Department of Health

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Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00750	B. WING		44/0	0/0040
NAME OF D	ROVIDER OR SUPPLIER	00758	DDRESS, CITY, STA	TE ZIR CODE	11/0	8/2013
			TH DOW STREE			
ANGELS	CARE CENTER	CANNON	FALLS, MN 55	009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From page	: 3	2 565			
2 565	Tater Tot Hotdish, bite approximately three of person had sat with Rassist or cue R21 to or had been sitting in dir hall/lobby area from divident independently an eight ounce glass malt-o-meal. R21 had to go to the bathroom had consumed appropriate and eaten three Dietary staff person hwith breakfast before R21 had stated I guessat with R21 during encourage R21 to eaten During observation or unopened container owith a date of 11/7/13 night stand, R21 had time. At 12:57 p.m., the R21's night stand under the person of the real statement of the R21 is night stand under the R21 is night stand	es out of cake, and drank uarters of juice. No staff (21 during entire meal to complete the meal.) 1 11/7/13, at 7:19 a.m., R21 (1) aing room located across ining room located by reating breakfast. R21 had of juice, cereal bowl of stated at 7:29 a.m., I have and left dining room. R21 (2) aing three quarters of quarters of malt-o-meal. (2) ad asked R21 if finished exciting dining room and (2) as so. No staff person had exciting dining room and (3) as so. No staff person had exciting meal to assist or entire meal. 1 11/7/13, 12:09 p.m., an of vanilla flavored ice cream on top had been on R21 's been in bed sleeping at this ne ice cream remained on opened. 1 17/13, at 12:57 p.m., (2)-E stated he had not R21.	2 565			
	staff pass out the sna resident's to eat the assist resident's to e R21's ice cream had staff between 10:00 a	se (LPN)-C stated kitchen				

Minnesota Department of Health

STATE FORM ETLH11 If continuation sheet 4 of 50

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00758	B. WING		11/08/2013	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ANGELS (CARE CENTER		H DOW STREE FALLS, MN 556			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
2 565	Continued From page	÷ 4	2 565			
	During interview on 1 of nursing stated she R21 needs more assi aware of R21's weighealth. Director of nur plan and verified the with meals and made should have assisted meals.	1/7/13, at 1:11 p.m., NA-D ered ice cream to R21. 1/7/13, at 2:16 p.m., director had heard at report that stance lately, had not been ht loss only decline in rsing looked at R21's care care plan read assist of one the comment that someone R21 to eat the snacks and				
	Document review of facility CARE PLAN POLICY AND PROCEDURE dated 8/2010, read, "Policy: It is the policy of Volunteers of America to provide a temporary care plan within 24 hours of admission (Admission Individual Care Plan) and a complete and comprehensive care plan by the resident 's 21st day of admission. The care plan will ensure the resident 's highest level of practicable function possible."					
	The director of nursin meal service to determ	OD OF CORRECTION: g or designee could monitor mine and establish staffing f nursing or designee could e.				
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty One				

6899

Minnesota Department of Health STATE FORM

ETLH11 If continuation sheet 5 of 50

Minnesota Department of Health

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S	
			A. BUILDING: _			
		00758	B. WING		11/0	08/2013
NAME OF PE	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ANGELS (CARE CENTER		H DOW STREE			
24.1.15	CLIMMADV CT	ATEMENT OF DEFICIENCIES	FALLS, MN 55		OF CORRECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
2 570	Continued From page 5		2 570			
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B.		2 570			
	by: Based on observation review, the facility fail interventions related (R56) reviewed for fa plan interventions to a speaking communica resident (R78) who of Findings include: R5 facility had assessed assisting R56 when the However, the interventiant of this concern On 11/6/13 at 8:00 a. observed to push R56 visit.	tion needs for 1 of 1 nly understood Spanish. 6 had frequent falls and the that family (F)-A had been he falls had occurred. ntion to remind F-A to seek led to be transferred had not care plan for staff to be				

Minnesota Department of Health

STATE FORM 6899 ETLH11 If continuation sheet 6 of 50

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	CONSTRUCTION	1 ' '	(X3) DATE SURVEY COMPLETED	
		00758 B. WING			11/	/08/2013
NAME OF PROVIDER (OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	-	
ANGELS CARE CE	NTER		TH DOW STREE FALLS, MN 55			
	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
history vertebring lincident found of Predispring impaired incident on floor hip pair motion. The quindicate and red bed modern poor definitions and red bed modern poor definitions and red bed modern poor definitions. The quindicate and red bed modern poor definitions are impaired demensions and poor definitions are impaired demensions. The quindicate and poor definitions are impaired demensions are impaired demensions. The quindicate are impaired demensions are impaired demensions. The quindicate are impaired demensions are impaired demensions. The quindicate are impaired demensions are impaired demensions. The quindicate are impaired demensions are impaired demensions. The quindicate are impaired demensions are impaired demensions. The quindicate are impaired demensions are impaired demensions. The quindicate and red poor definitions are impaired demensions. The quindicate and red poor definitions are impaired demensions. The quindicate are impaired demensions are impaired demensions are impaired demensions. The quindicate are impaired demensions are impaired demensions are impaired demensions. The quindicate are impaired demensi	a fractures. In this part of the property of the property of a pair of pair with which of the property of a pair of pair with the property of a pair of pair with which of pair with wh	d 9/25/13 read that R56 was es holding the bed. included gait imbalance and o injury was noted. dd 10/13/13 R56 was found ed. R56 complained of right difficulty with range of m Data Set dated 10/22/13 everally cognitively impaired we assistance with transfers, not walk. Fall Risk 19/13 indicated R56 was at a related to cognitive deficits, urinary incontinence, a eight bearing, medications, ted behaviors. ated identified a problem of a risk for falls related to on, osteoarthritis, enced by a history of falls, areness, need assist with an lacked an intervention or e not to help the resident A)-B was interviewed on NA-B stated she thought ad been trying to transfer to intervene if they see this I she has never seen R56	2 570			

Minnesota Department of Health

STATE FORM ETLH11 If continuation sheet 7 of 50

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		00758	B. WING		11	/08/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
ANGELS	CARE CENTER		TH DOW STREE FALLS, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 570	transferring R56 along falling. CM-B stated I much as possible and not to help transfer R5 this occurs. During an interview or director of nursing vernot include an intervers. During an interview or director of nursing vernot include an intervers. R78 had been assess English as a spoken I language as they only. R78 had been admitted diagnoses that include brain damage, aphasis. Minimal Data Set (ME preferred language S rarely/never understor assessment (CAA) we identified nature of the essentially non-verbad damage, aphasia, princharacteristics of the R78's care plan review vulnerable adult as deand is unable to commintervention of use inthad no other intervencommunication needs.	now that F-A had not been e as much, R56 was not F-A liked to help C56 as dineeded reminders by staff 56 alone as R56 falls when in 11/8/13 at 12:20 p.m. the rified R56 's care plan didintion related to reminding 56 and get help if R56 needs erred. Seed to not understand anguage or as a written y understood Spanish. Seed on 6/4/13. R78 had ed but not limited to anoxic ia. R78's significant change OS) dated 10/15/13 identified panish, no speech, od. R78's care area orksheet dated 10/21/13, se problem/condition: I related to anoxic brain mary language Spanish and communication impairment. W date 10/22/13, identified epends on staff for all cares municate with only erpreter. R78's care plan tions to promote	2 570			
	During observation or	n 11/4/13, at 1:09 p.m				

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		00758	B. WING		11	/08/2013
	ROVIDER OR SUPPLIER	300 NOR	DDRESS, CITY, STATE TH DOW STREET I FALLS, MN 5500			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 570	in English and had stanot speak English, Ratalk. She had stated in Spanish. The television room and had been on R78 to watch. During interview on 1 service person stated English, is non-verbanot worked with R78 and communication. Shad talked about interview on 1 nursing assistant (NA Spanish. NA-E stated use hand gestures. Not development gave as English words convertion However, this was not of the care plan. During interview on 1 therapist stated she ponly for R78. Speech tried some communicand there was no resverified there is no do notes regarding committed in the staff in the	in R78's room talking to R78 ated to surveyor R78 does 78 looks at you but does not R78's language was on had been on in R78's in the Spanish channel for 1/7/13, at 8:44 a.m., social R78 does not speak and speech therapy had regarding language barrier Social service stated she repreter with family, not sure 1/7/13, at 12:55 p.m., a)-E stated I do not speak at I talk to R78 in English and A-E stated staff sheet with some simple ted to Spanish for us to use. It used routinely and not part 1/7/13, at 2:00 p.m., speech provided swallow therapy therapist stated she had ation in Spanish with R78 ponse. Speech therapist ocumentation in therapy munication and had not fit to use for communication. Ified R78 understands and	2 570			
	speaks Spanish only. During interview on 11/8/13, at 11:10 a.m., director of nursing verified R78 understands and speaks Spanish only. Director of nursing stated she would expect interpreter to help					

Minnesota Department of Health

STATE FORM ETLH11 If continuation sheet 9 of 50

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY			
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	COMPLETED		
		00758	B. WING		11/08/2013	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ANGELS	CARE CENTER	300 NORTH	H DOW STREE	т		
ANGLES	DAIL CLITTER	CANNON F	ALLS, MN 55	009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
2 570	Continued From page	9	2 570			
	communicate and involve family to communicate. Director of nursing stated she would expect communication to be care planned.					
	SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could educate staff related to the need to evaluate and update care plans and monitor for compliance.					
	TIME PERIOD FOR CORRECTION: Twenty One (21) days.					
2 800	MN Rule 4658.0510 Staffing requirements	Subp. 1 Nursing Personnel;	2 800			
	Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements.					
	This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure sufficient staffing to meet the needs for 17 of 17 residents on the dementia unit and 59 total residents in the facility at the time of the survey.					
	did not receive timely	6, R63, R65, R68, R37, R73 assistance during meals. t was observed during the 3 and 11/6/13.				

Minnesota Department of Health STATE FORM

6899 ETLH11 If continuation sheet 10 of 50

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING	A. BUILDING:		
		00758	B. WING		11/	/08/2013
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ANGELS (CARE CENTER		H DOW STREE			
		CANNON	FALLS, MN 55	009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 800	Continued From page	e 10	2 800			
	On 11/4/13 during the noon meal 16 residents were in the memory care dining room. It was observed at the start of the meal that no resident had their hands washed before meals were served to the residents and several of the residents used their fingers to eat their foods. On 11/6/2013 at 12:29 p.m. 16 residents were in the memory care dining room with one nursing assistant to supervise, cue, and feed. A nursing assistant was in a resident room to feed that resident. The licensed practical nurse assisted residents to eat. R66 had not been assisted to eat. On 11/4/13 R66 was not assisted to eat while other residents at the table ate independent. R66 sat with food on table and not assistance for a total of 37 minutes. On 11/6/2013 R66 again received a food tray at 12:15 p.m. and made no attempt to eat and soon fell asleep in the wheelchair. No staff encouraged or assisted R66 to eat until 12:43					
	Minimum Data Set as identified R66 as sever	28 minutes A Quarterly assessment dated 8/12/2013 erely cognitively impaired by assist of one for eating.				
	R63 had not been cued to eat, not to eat cake with fingers verses using a fork and foods were not checked for coldness after setting for 38 minutes from the time the food was delivered to the unit and when R63 began to eat the food. On 11/6/13 R63 received a meal tray at 12:15 p.m. R63 's food tray had been uncovered but not served to them for 20 minutes prior to this. R63 was observed to be sleeping from the time the food was placed in front of her until she awoke at 12:33 p.m. R63 took the milk and started drinking some after this R63 dumped the piece of cake unto the plate and grabbed the cake with her fingers. There was no staff cueing to encourage					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		00758	B. WING		11	/08/2013
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
ANGELS	CARE CENTER		TH DOW STREET I FALLS, MN 55009	9		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 800	or to use a fork to eat dated 9/6/2013 identific cognitively impaired a cueing after set up of R65 had been observed hand during the meal encourage her to weat was observed during use a fork to eat while with her fingers, take place it back on the pform 12:01 p.m. to 12 encouraged by staff to eat the meal nor had the fork to eat the foointerview on 11/7/13 apractical nurse (LPN) encourage R65 to we At breakfast that morn observed to have the asked by LPN-D to pl mouth, R65 allowed L remove the dentures R38 was not assisted manner. On 11/4/13 aprovided the meal that minutes earlier. The to eat and no staff assiminutes. During that with the clothing protes the table ate. A quarte assessment dated 10 as severely cognitivel limited assist of one significant control of the second contro	then it was set in front of her the cake. A quarterly MDS fied resident as severely and required supervision and meal. The detection of the care and no staff attempted to at the lower denture. R65 the noon meal on 11/6/13 to be clutching her dentures, eat food out of her mouth and late. During the entire meal to use her bottom denture to they encouraged her to use ds provided. During an at 8:30 a.m. licensed at 8:30 a.m. licensed at the dentures while eating. The care the dentures in the the dentures in the the dentures in the the dentures in the the dentures in the the denture of the meal. I during dining in a timely at 12:25 p.m. R38 was at had arrived on the unit 13 resident made no attempt sisted the resident played ector while other residents at early minimum data set 16/2013 identified resident y impaired and required	2 800			
	R37 was not consiste	-				

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	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00758	B. WING		11/08	3/2013	
	ROVIDER OR SUPPLIER	300 NORT	DRESS, CITY, STA H DOW STREE FALLS, MN 55	T			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)) BE	(X5) COMPLETE DATE	
2 800	to assist her to eat. A 9/5/2013 identified the cognitively impaired a cueing of one staff for R73 was not assisted the noon meal on 11/30 minutes after it arr 30 minutes (12:12 to observed to propel the dining room as the ott R82 and R56 were not pound on the table for On 11/4/2013 at 1:45 11/7/2013 at 9:00 a.m regarding dining obset LPN-D stated it had be residents to wait to east affing. LPN-D said nursing assistant and shift for 17 residents was assistance. The residents to eat as had staff been able to closely during dining lead assisted to eat. LACK OF ASSISTAN NAIL CARE: See F312 for example received finger nail care.	eresident as moderately and required supervision and reating in a timely manner during 4/13. R73 received her food ived on the unit. During this 12:45 p.m.) R73 was a wheelchair about the ner residents ate. Residents ated to yell at R73 and then rextended periods of time. p.m. and again on and again o	2 800				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION (X3			
7.1.12 . 2.1.1	o. 0012011011	.5	A. BUILDING:			LETED
		00758	B. WING		11/	08/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
411051.0	04 DE 05NTED	300 NOF	TH DOW STREET			
ANGELS	CARE CENTER	CANNO	N FALLS, MN 5500	9		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 800						
	OF CARES FOR LOV MEMORY CARE UNI					
	R56's family member (F)-A on 11/5/13 at 6:04 p.m. stated care was getting worse. Now only have one staff, sometimes two to get R56 ready for bed and R56 goes to bed later as a result of reduced staff to help residents. R47's F-B filed a complaint with the Office of Health Facility Complaints (OHFC) dated 10/10/2013 with the complaint as written, "It is alleged that the facility did not provide adequate Staff to monitor and safety and hygiene of the residents [R47]." The following was found concerning F-B 's complaint on investigation during the survey:					
	R47 had long dirty find had said she would ta complaint written by FOn 9/29/13 F-B docur nursing indicated ther staff to meet the need memory care unit but pull them [nursing assisted the NH [nursing home 12:00 noon on 9/29/1] residents waiting for tocart had been in the distaff members helping table, so the food was until 12:30 p.m. On 9/been with R47 all day p.m., and that R47 had brief changed this entil	ated residents other than gernails and that the nurse ake care of it according to F-B and given to the facility. The mented the director of the should be a minimum of 3 at sof the residents on the street of the DON said, "We need to sistants] for other areas of the interest of the should be a minimum of 3 at sof the residents on the street of the sistants of the street of the should be a soft of the should be sho				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		00758	B. WING		11	/08/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATE	E, ZIP CODE		
ANGELS	CARE CENTER		TH DOW STREET			
			FALLS, MN 5500			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 800	2 800 Continued From page 14					
	at which time the DOI employees were quitt learning what to do.					
	R47 and had a couple resolve the concerns. concerns voiced by se	3 at 1:50 p.m. LSW				
	11/8/13 at 11:00 a.m. required a minimum s assistants on days an needs of the residents safety. CM-B stated it the unmet cares that nurses were not alwa CM-B said that the refor bathing may not gone staff on that day. need assistance to eaperiods of time to be a felt that the number of	(CM)-B was interviewed on She indicated the unit taffing level of 2 nursing devening to meet the sand provide for their thad been "Awful" due to all residents don 't get and that ys available to help either. Sidents who need two staffest a bath as there is only Also the residents who at may have to wait long assisted. CM-B stated she falls have increased and ecause of the low staffing on				
	as they were afraid of against, so date and t included) said that the is short of staff they a Memory care unit sho staffing and the staff of that they don't need	uested not to be identified being fired or retaliated ime of interview was not ey had been told if the floor re to pull one from the orting the memory care on the memory care are told to do bathing or showers for priority. F-A said this occurs				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00758	B. WING		11/0	8/2013
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA I DOW STREE			
ANGELS	ANGELS CARE CENTER CANNO					
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
2 800	Continued From page	e 15	2 800			
	frequently that staff is pulled from the Memory care unit and resident don't receive baths often. The administrator and director of nursing were interviewed on 11/8/13 at 2:30 p.m. They both said that they had identified the same concern with staffing level in the facility. They both said that it was also discussed at the Quality Assessment and Assurance Committee. The director of nursing indicated they had identified during meals and getting residents up in the a.m. and ready for bed was the most difficult to get done related to short staffing. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing, and/or designees could evaluate the services needed by residents in the dementia unit to determine					
	-	onitor for compliance.				
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that:		2 895			
	receives appropriate	a limited range of motion treatment and services to tion and to prevent further motion.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00758	B. WING		11	1/08/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
ANGELS	CARE CENTER		RTH DOW STREET	_		
	0,111,120,407		N FALLS, MN 5500		00000000000	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 895	Continued From page	e 16	2 895			
	by: Based on observation review, the facility fair motion services (ROI physical therapist for reviewed for range of Findings include: R52 did not receive to ruse the hand/finge the physical therapist. R52 was observed on in bed and on 11/05/3 observed sitting in the to open right hand, Rout fingers on right happresent. During observed sitting in the physical therapist of the physical therapist. During observed sitting in the physical therapist of the physical therapist of the physical therapist observed sitting in the present. During observed sitting in the present. During observed sitting in the present. During observed in the present of the physical physic	the range of motion services or splint as recommended by the services of the splint as recommended by the splint as recommended by the splint as the splint as the splint as the splint and the splint had been envations on 11/7/13 from the splint had been envations on 11/7/13 from the splint had been envations on 11/7/13 from the splint as the splint a				
	nursing assistant (NA contracted hand show					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00758	B. WING		11/08/2013	
	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
ANGELS	CARE CENTER	CANNON F	ALLS, MN 55	009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE CO	(X5) MPLETE DATE
2 895	Continued From page 17		2 895			
	therapy would do it. NA-A then said they don 't use a splint because they had used a rolled up rag. R52 's ROM documentation indicated staff was to document amount of minutes they provide ROM. Restorative Passive Range of Motion right upper extremity 10 repetitions twice a day. Documentation of ROM provided to R52 from 10/9/13 through 11/6/13 was provided and it had been done inconsistently during this time. The Therapy to Nursing Communication dated 4/2/13 indicated passive range of motion right arms twice a day and lower extremity stretches twice a day. Right hand contracture splint on at bedtime and off in morning. Clinical Manager (CM)-A was interviewed on 11/7/13 at 12:30 p.m. CM-A stated she had found a computer problem with the range of motion documentation. On 4/2/13 physical therapy had ordered upper extremity and lower extremity range of motion and a hand contracture splint to be worn on the right hand/fingers. This information had not been transferred to R52 's care plan. Therefore only the upper extremity had ROM completed.					
	The director of nursin transcription of physic	aluate staff provision of				
	TIME PERIOD FOR ((21) days.	CORRECTION: Twenty One				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00758	B. WING		11/08/2013	
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
ANGELS (CARE CENTER		TH DOW STREE FALLS, MN 55			
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION	N (VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
2 920	Continued From page	e 18	2 920			
2 920	MN Rule 4658.0525	Subp. 6 B Rehab - ADLs	2 920			
	Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure each resident received grooming assistance as needed for 4 of 4 residents (R47, R56, R65 and R21) reviewed for activities of daily living (ADLs.)					
	trimming and cleaning	7 lacked assistance for g of finger nails.				
	On 10/10/13 R47's family (F)-A provided a written complaint to the Minnesota Department of Health related to lack of care F-A felt R47 had received during stay at the nursing home. The written complaint indicated that on 8/29/13 R47's had long and dirty fingernails and F-A had spoken with the director of nursing. The written complaint noted that again on 9/21/13 R47 again had long and dirty fingernails. The complaint also noted that other residents in the special care unit had long dirty fingernails. R47 was admitted to the facility in 2010 and resided on the special care unit for residents with dementia. The quarterly Minimum Data Set dated 9/12/13 indicated R47 was severely cognitively impaired and required extensive assistance with all ADLs including personal					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	00758	B. WING		11/	08/2013	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
ANGELS CARE CENTER		TH DOW STREE FALLS, MN 55				
PREFIX (EACH DEFICIENCY I	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CONTROL OF THE PROCEDED BY FULL CONTROL OF T	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE	
unit and had diagnoses anxiety, depression, os hip fracture. The CAA assistance with ADLs. 10/3/13 noted an interv bathing as needed." The director of nursing 11/8/13 at 2:50 p.m. D of F-A's concerns whis summer. DON stated a were about R47's fing had been disappointed concern a couple mont transferred to another h complained of R47 not R56 lacked trimming an R56 was observed on was noted to have long nails on both hands. Or was observed in the who nails were observed to under nails on both har The quarterly MDS date The MDS indicated R56 impaired and required one for personal groom. The care plan provided problem of self-care deand grooming related to Alzheimer's evidenced complete ADL's. Nursing assistant (NA) on 11/8/13 at 9:49 a.m.	ea assessment (CAA) d R47 lived on the memory is that included dementia, steoarthritis and history of noted R47 needed The care plan dated vention of "nail care after (DON) was interviewed on ion stated she was aware ch were reported this last she remembered concerns ger nails. DON stated they I that F-A had the same this later. R47 had been home after F-A had getting adequate cares. Ind cleaning of finger nails. 11/4/13 at 12:11 p.m. R56 g and dark colored fingers in 11/6/13 at 8:00 a.m. R56 heelchair. R56 's fingers remain long and soiled inds. Index 10/22/13 was reviewed. It is was severely cognitively extensive assistance of ining and bathing. In 11/6/13 identified a efficit in dressing, bathing,	2 920	DEFICIE	NCI)		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		00758	B. WING		11	1/08/2013
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	E, ZIP CODE	,	
ANGELO	CARE CENTER	300 NOF	RTH DOW STREET			
ANGELS	CARE CENTER	CANNOI	N FALLS, MN 5500	9		
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETE DATE
2 920	11/8/13 at 11:00 a.m. had been an issue for residents. Sometime CM-B had not been to be cleaned and trimm R65 lacked personal fingernails. The resident has had and 10/2 on skin audi written for fingernail of Documentation for 10 11/6/2013 identify the was totally dependen none found and there regarding trimming of On 11/5/2013 at 3:00 fingernails approxima underneath nails. On meal time at 12:12 p. eating cake with long 11/7/2013 at 1:30 p.m observed with long di 11/8/2013 at 9:00 a.m	rim nails in the past. I)-B was interviewed on She indicated that staffing meeting the needs of the s R56 refused cares, but old about need for nails to need. hygiene related to a bath documented on 9/11 t forms and nothing was are either time. I/9, 10/16, 10/23, 10/30, and resident had a bath and t. Skin check areas noted was no documentation fingernails, shaving, etc. p.m., R65 had long tely 1/2 inch long and dirty 11/6/2013 during the noon m., R65 was observed dirty looking finger nails. On n., R65 gain had been	2 920			
	It noted: Self-care-de grooming due to dem assistance to comple Bathing: 1 assist to coindependence with up bathing as needed. Rurse. PERSONAL H	oper body. Nail care after eport any changes to the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00758	B. WING	<u></u>	11	/08/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
ANGELS	CARE CENTER		TH DOW STREET			
		CANNON	N FALLS, MN 5500	09		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 920	Continued From page	21	2 920			
	upper body.					
	as severely cognitivel	11/2013 identified resident y impaired and required se staff for personal hygiene g.				
		p.m., nurse aide (NA) - G o resident nails on bath days				
	manager (CNM)-B stachecking finger nails in needed. The policy entitled Nadated 2006 noted the cleanliness, prevent sto prevent skin proble include the frequency policies entitled Bath	O a.m., a clinical nurse ated the staff should be every bath day and trim if alls Care of (Finger and Toe) purpose as to provide spread of infection, comfort, ems. The procedure did not of nail care. The facility (partial) dated 2006 and 6, directed staff to "care of Is is part of the bath."				
	R21 had not been assaccording to R21's pla	sisted with meals or snacks an of care.				
	Data Set (MDS) dated	ed but not limited to write malnutrition, and the R21's admission Minimum to 8/29/13, indicated R21 had liental status (BIMS) score of				
	focus: nutrition alteration	ion dated 11/1/13, indicated tion per cognitive changes, altered meats, one assist entions: diet per physician sists to eat all meals.				

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	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	ETED	
		00758	B. WING		11/0	8/2013	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE			
		300 NORT	H DOW STREE	т			
ANGELS	CARE CENTER		FALLS, MN 550				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE	
2 920	R21 's physician orders dated 10/30/13, indicated snacks three times daily between meals to prevent weight loss. Document review of R21 's dietary progress note dated 10/24/13, indicated weight loss, carb controlled diet, and meats are ground, between meal snacks. R21 to be encouraged to consume. During observation on 11/6/13, at 11:58 a.m., R21 had been sitting in dining room located across hall/lobby area from dining room located by kitchen independently eating lunch. Dietary staff approached R21 once and asked R21 if doing ok and R21 had replied yeah, good. R21 had Tater-Tot Hotdish and green beans on a plate, a dish with cake and one eight ounce glass of juice. R21 consumed one half of Tater-Tot Hotdish, bites out of cake, and drank approximately three		2 920				
	R21 during entire me						
	had been sitting in dir hall/lobby area from continuous continuous distribution of the continuous distribution distr	ting dining room and R21 . No staff person had sat					
	unopened container of	of vanilla flavored ice cream on top had been on R21's					

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Minnesota Department of Health

PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL		STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER ANGELS CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH DOW STREET CANNON FALLS, MN 55009 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG COMPL TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DAT 2 920 Continued From page 23 night stand, R21 had been in bed sleeping. At 12:57 p.m., the ice cream remained on R21's night stand unopened. During interview on 11/7/13, at 12:57 p.m., nursing assistant (NA)-E stated he had not			00758	B. WING		11/08/2013	
ANGELS CARE CENTER CANNON FALLS, MN 55009 (X4) ID PREFIX TAG CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 920 Continued From page 23 night stand, R21 had been in bed sleeping. At 12:57 p.m., the ice cream remained on R21's night stand unopened. During interview on 11/7/13, at 12:57 p.m., nursing assistant (NA)-E stated he had not	NAME OF P	PROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	1 17007	2010
PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) 2 920 Continued From page 23 night stand, R21 had been in bed sleeping. At 12:57 p.m., the ice cream remained on R21's night stand unopened. During interview on 11/7/13, at 12:57 p.m., nursing assistant (NA)-E stated he had not	ANGELS	CARE CENTER					
night stand, R21 had been in bed sleeping. At 12:57 p.m., the ice cream remained on R21's night stand unopened. During interview on 11/7/13, at 12:57 p.m., nursing assistant (NA)-E stated he had not	PREFIX	(EACH DEFICIENC	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
During interview on 11/7/13, at 12:57 p.m., licensed practical nurse (LPN)-C stated kitchen staff pass out the snacks but do not assist resident's to eat, nursing staff assist resident's to eat snacks. LPN-C stated R21's ice cream had been passed out by dietary staff between 10:00 a.m. and 10:15 a.m. LPN-C stated she had not offered ice cream to R21. During interview on 11/7/13, at 1:11 p.m., NA-D stated he had not offered ice cream to R21. During interview on 11/7/13, at 2:16 p.m., director of nursing stated she had heard at report that R21 needs assistance lately, not aware of weight loss only decline in status. Director of nursing looked at R21 's care plan and verified care plan read assist of one with meals and stated so yes, someone should be assisting with snacks and meals. Document review of facility FEEDING A RESIDENT dated 2006, read "Policy 1. Residents who need assistance will be fed a well-balanced meal, by RN, LPN, or CNA. Procedure 8. Tell the resident that you are going to be seated during the feeding, staff to position chair where it will be convenient for both them and the resident." SUGGESTED METHOD OF CORRECTION: The director of nursing could monitor personal	2 920	night stand, R21 had 12:57 p.m., the ice or night stand unopened. During interview on 1 nursing assistant (NA offered ice cream to I During interview on 1 licensed practical nurstaff pass out the snaresident's to eat, nurseat snacks. LPN-C state been passed out by a.m. and 10:15 a.m. I offered ice cream to I During interview on 1 stated he had not offer During interview on 1 of nursing stated she R21 needs assistance loss only decline in stated assist of one with someone should be a meals. Document review of for RESIDENT dated 200 who need assistance meal, by RN, LPN, or resident that you are the feeding, staff to p convenient for both the SUGGESTED METH.	been in bed sleeping. At earn remained on R21's 1/7/13, at 12:57 p.m., DE stated he had not R21. 1/7/13, at 12:57 p.m., Se (LPN)-C stated kitchen cks but do not assist ing staff assist resident's to reted R21's ice cream had retary staff between 10:00 PN-C stated she had not R21. 1/7/13, at 1:11 p.m., NA-D red ice cream to R21. 1/7/13, at 2:16 p.m., director had heard at report that relately, not aware of weight refuse. Director of nursing plan and verified care plan in meals and stated so yes, resisting with snacks and recility FEEDING A red "Policy 1. Residents will be fed a well-balanced CNA. Procedure 8. Tell the going to be seated during resident." DD OF CORRECTION:	2 920			

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WIIIIIICSOL	a Department of Fleatti	 			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			B. WING		
		00758	B. WING	·····	11/08/2013
NAME OF PR	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE	
		300 NOR	TH DOW STREE		
ANGELS (CARE CENTER		FALLS, MN 55		
		CANNON	TALLS, WIN 55	UU3	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(- /
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	<u> </u>
IAG	TEODERION ONE	iso is live in ordination,	TAG	DEFICIENCY)	,,,,,
				·	
2 920	Continued From page 24		2 920		
	resident/staffing needs, educate staff, and monitor for compliance.				
	monitor for complianc	e.			
	TIME DEDICE FOR	CORRECTION T 1 0			
		CORRECTION: Twenty One			
	(21) days.				
21015	MN Rule 4658.0610 S	Subp. 7 Dietary Staff	21015		
	Requirements- Sanita	ary conditi			
	Subp. 7. Sanitary co	inditions. Sanitary			
		itions must be maintained in			
	•	ietary department at all			
	times.	iotaly apparament at an			
	umoo.				
	This MN Requiremen	t is not met as evidenced			
	by:				
		n, interview, and document			
		ed to maintain a sanitary			
	•	nt the spread of food borne			
	•	I food handling practices,			
		- -			
		and sanitizing, drying and			
		resident food use. This had			
	·	57 of 57 residents in the			
	-	provided food prepared and			
	distributed from the fa	acility kitchen.			
	•	ing initial tour of kitchen on			
	11/4/13, at 9:10 a.m.,				
		a fan attached to wall with a			
		and was blowing directly			
	onto clean dishes. Als	so there had been a stand			
	fan with a layer of dus	st build up sitting directly			
	beside clean dishes.				
	Sanitation of dishes w	vas compromised due to			
		ure had not reached the			
	range of 120 degrees				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		1 ' '	(X3) DATE SURVEY COMPLETED	
ANGELS CARE CENTER 300 NORTH DOW STREET CANNON FALLS, MN 55009 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE			00758	B. WING		11/	08/2013	
ANGELS CARE CENTER CANNON FALLS, MN 55009 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE CROSS-REFERENCED TO THE APPROPRIATE DATE	NAME OF PROV	VIDER OR SUPPLIER						
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	ANGELS CA	ARE CENTER						
	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
During observation on 11/6/13, at 9:18 a.m., cook helper (CH)-C had been observed washing a load of dishes and verified with surveyor at the time the temperature of wash cycle had reached 115 degrees Fahrenheit. CH-C pushed the load of dishes out of dishwasher and proceeded to start another load of dishes and again verified with surveyor at the time the temperature of wash cycle had reached 115 degrees Fahrenheit. CH-C pushed the load of dishes out of dishwasher and proceeded to start another load of dishes and again verified with surveyor at the time the temperature of wash cycle had reached 111 degrees Fahrenheit. During interview on 11/6/13, at 9:32 a.m., dietary director stated she would expect staff to stop washing dishes in the dishwasher if the water had not reached appropriate temperature, use three compartment sink instead of dish washer to sanitize dishes and staff is to notify her that the dishwasher was not working and she would call ECO lab company. Dietary director washed a load of dishes at this time and verified the dishwasher temperature had only reached 110 degrees Fahrenheit, not 120 degrees Fahrenheit as required to sanitize the dishes. Dietary director then said she would call ECO Lab Company immediately. Document review of facility Cleaning Dishes/Dish Machine dated 2010, read "Policy: All flatware, serving dishes, and cookware will be washed, rinsed, and sanitized after each use. Dish Machines will be checked prior to meals to assure proper functioning and appropriate temperatures for cleaning and sanitation. Procedure: Prior to use, run the machine until verification of proper temperatures and machine function is made. Verify the soap and rinse dispensers are filled and have enough cleaning product for the shift. The facility had not maintained sanitary conditions	Dhi o' ttr da di a si c' Di di wi na ca si di E lo di di a si ttr in Di Mi si te Pi vi fi di pi	During observation or nelper (CH)-C had be of dishes and verified he temperature of wategrees Fahrenheit. Of dishes out of dishes another load of dishes arother load of dishes surveyor at the time the cycle had reached 11: During interview on 12 director stated she wow washing dishes in the not reached appropriate compartment sink instantize dishes and statishwasher was not we ECO lab company. Dispond of dishes at this faishwasher temperatures Fahrenheit, rates required to sanitize then said she would commediately. Document review of fawachine dated 2010, serving dishes, and coinsed, and sanitized awachines will be check assure proper function to the control of the said she would comperatures for clean procedure: Prior to us werification of proper to dispensers are filled a product for the shift. "	an 11/6/13, at 9:18 a.m., cook then observed washing a load with surveyor at the time ash cycle had reached 115 CH-C pushed the load of ther and proceeded to start is and again verified with the temperature of wash 1 degrees Fahrenheit. 1/6/13, at 9:32 a.m., dietary build expect staff to stop a dishwasher if the water had atte temperature, use three tead of dish washer to the tead of dish washer to the teatry director washed a time and verified the cure had only reached 110 mot 120 degrees Fahrenheit at the dishes. Dietary director call ECO Lab Company acility Cleaning Dishes/Dish read "Policy: All flatware, cookware will be washed, after each use. Dish cked prior to meals to ning and appropriate ning and sanitation. See, run the machine until temperatures and machine ify the soap and rinse and have enough cleaning	21015				

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Minnesota Department of Health						
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
			B. WING			
		00758	B. WING		11/08	/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		300 NOR	TH DOW STREE	T.		
ANGELS (CARE CENTER		FALLS, MN 55			
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTIO	N	(VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE	DATE
				DEFICIENCY)		
21015	5 Continued From page 26		21015			
	. •					
	During the taking of for					
		., cook (C)-A had been				
	holding utensils in ha	nds and held utensils up				
	against uniform/apror	n before laying them down				
	on a towel in front of	steam table containers. C-A				
	had put thermometer	in chicken to check				
	temperature and had	not cleaned the				
	thermometer prior to	using it. C-A had gloves on				
	and had touched a do	oor handle to open door of				
	closet, grabbed a wipe with same pair of gloves					
	and proceeded to use	e the wipe to clean				
	thermometer between	n checking different foods				
	temperatures. While t	aking the food temperatures				
	in steam table contain	ners cook-A had been				
	observed leaning ove	r utensils and touching				
	utensils with apron.					
	On 11/7/13, at 11:19 a	a.m., CH-B had been				
	observed to grab ther	mometer out of pencil				
	holder which had just	been used to check food				
	temperatures from the	e steam table by C-A and				
	placed the un-cleaned	d thermometer into pudding				
	to check temperature	. CH-C verified she had not				
	cleaned the thermom	eter prior to putting in the				
	pudding that was to b	e served to the resident.				
	During meal service of	observation on 11/7/13, at				
	11:29 a.m., dietary dir	rector was observed picking				
	up lettuce and tomato	bes out of containers with				
	soiled gloved hands a	and placing them on a plate				
		gloves on that had touched				
	handles of a drawer a					
		1/7/13, at 11; 46 a.m.,				
		ed they had grabbed lettuce				
		ood containers with same				
		hat had touched handle of				
	drawer and refrigerate					
	_	1/7/13, at 1:55 p.m., dietary				
		spected staff to not touch				

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utensils with uniform, should wash thermometer before use and not store thermometer with dirty items and expected gloves to be changed when

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:	, , ,	(X3) DATE SURVEY COMPLETED		
		00758	B. WING		1	1/08/2013
	ROVIDER OR SUPPLIER	300 NOF	DDRESS, CITY, STATE RTH DOW STREET N FALLS, MN 5500			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21015	soiled. Document review of with Food and Use of read " Procedure: 6 like hands. They get contaminated surfact be changed." SUGGESTED METH. The administrator and educate staff related monitor for compliant.	facility Bare Hand Contact of Plastic Gloves dated 2010, Remember gloves are just soiled. Anytime a e is touched, the gloves must HOD OF CORRECTION: and dietary manager could to dietary sanitation and	21015			
21375	Program Subpart 1. Infectior home must establish	Subp. 1 Infection Control; n control program. A nursing and maintain an infection igned to provide a safe and t.	21375			
	by: Based on observation review, the facility fat to prevent the possible infections during blood performed for 1 of 1 blood sugars reading glucose machine. Findings include: R4 sanitized with an antitized with an antitized borne infections. Als	int is not met as evidenced in, interview, and document iled to implement procedures ble spread of blood borne od glucose monitoring resident (R42) who had gs taken with the use of a 2's glucometer had been i-microbial agent but should with an agent that kills blood of the nurse had not used hen sanitizing a soiled				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		00758	B. WING		11	/08/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
ANGELS	CARE CENTER		RTH DOW STREET N FALLS, MN 5500	9		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21375	contact with blood bo R42 was observed to 11/4/2013 at 11:45 a. test by licensed pract was observed to rem a drop of blood on it a had rolled up in a glor medication cart, LPN- wipes to wipe the glur any barrier but used b glucometer that had or resident 's blood. On wiped, LPN-D immed the medication cart at minute drying time to glucometer. The Material Safety D identified the hand wi wipes. It has alcohol On 11/8/2013 at 4:00 was interviewed rega cleansing of glucome verified the staff shour required gloves and w PDI cleanser (alcohol used. Some staff ma enough. Document review of to Disinfecting Blood Gli Health Services Infect was provided by the f wipes have a 2- minut HBV, HBC, diseases	have blood drawn on m., for a blood glucose level ical nurse (LPN)-D. LPN-D have the test strip which had and disposed it by having we. Upon returning to the -D used PDI Sani Hands cometer but had not used bare hands to wipe the come in contact with the ce the glucometer was iately put the glucometer in and had not allowed the two properly sanitize the Data Sheet for PDI product pes as antimicrobial alcohol as the active ingredient. p.m., the director of nursing rading products to use for the equipment. She lid be using the cleanser that was the most stringent. The libased) is not the one to be any not be educated well the facility Cleaning and ucose Meters from Pathway tion control manual 2010 facility. 15. the Sani-cloth te time for disinfecting HIV, which are approved by the es. 16. Sani-cloth wipes is	21375			

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: COMPLET		TED	
		00758	B. WING		11/08	3/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		300 NORTH	H DOW STREE	т		
ANGELS	CARE CENTER	CANNON F	ALLS, MN 55	009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
21375	Continued From page	29	21375			
	sheet when using the	es must be worn per MSDS Sani-Cloth wipes.				
	The director of nursin staff on the appropria patient use equipmen	OD OF CORRECTION: g or designee could educate te cleaning of multiple it to prevent cross en monitor for compliance.				
	TIME PERIOD FOR ((21) days.	CORRECTION: Twenty One				
21426	MN St. Statute 144A. Prevention And Contr	04 Subd. 4 Tuberculosis rol	21426			
	maintain a comprehei infection control progreurrent tuberculosis ir issued by the United Control and Prevention Tuberculosis Eliminat Morbidity and Mortalit This program must in infection control plan unpaid employees, coresidents, and volunte Health shall provide to regarding implementations.	ram according to the most affection control guidelines States Centers for Disease on (CDC), Division of ion, as published in CDC's ty Weekly Report (MMWR). Colude a tuberculosis that covers all paid and contractors, students, eers. The Department of echnical assistance ation of the guidelines.				
	(b) Written complian be maintained by the	ce with this subdivision must nursing home.				
	This MN Requiremen	t is not met as evidenced				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00758	B. WING		11/0	8/2013
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA			
ANGELS (CARE CENTER		H DOW STREE FALLS, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
21426	facility failed to complete assessment according Disease Control (CDC) the transmission of Turberculosis Risk Ass. The facility TB risk as completed Septembe written due 2016. The TB Risk Assessm 10, 2012, revealed the reviewed and updated recommends that messettings update their reviewed and low-risk heat their worksheet every. During interview on 1 director of nursing (Deassessment was command due 2016 accord DON verified was not assessment needed to SUGGESTED METHOTHE Director of Nursing assessment would be CDC recommendation.	and document review the ete a Tuberculosis (TB) risk g to the current Centers for C) guidelines for preventing uberculosis. facility lacked an updated sessment Worksheet. sessment had been r 2011 and had been hand ment information dated April e assessment should be d periodically. MDH dium-risk health care risk assessment worksheet ealth care settings update other year. 1/8/13, at 11:03 a.m. the ON) verified the TB risk pleted in September 2011 ing to the worksheet. The sure when a new TB risk o be completed. OD FOR CORRECTION: ng would ensure the TB risk is completed according to the	21426			
21530	MN Rule 4658.1310 A	A.B.C Drug Regimen Review	21530			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVE	Y
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			Ι -	_	1	
			D MANAGO			
		00758	B. WING		11/08/20 ⁻	13
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE ZIP CODE		
TVAINE OF T	TOVIDER OR OUT FEIER					
ANGELS (CARE CENTER		I DOW STREE			
		CANNON F	ALLS, MN 55	009		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		MPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIAIE	DATE
				DEFICIENCY)		
21530	Continued From page	31	21530			
	Continued From page	. 01				
	 A. The drug regimen 	of each resident must be				
	reviewed at least mor	nthly by a pharmacist				
	currently licensed by t	the Board of Pharmacy.				
		lone in accordance with				
	Appendix N of the Sta	ate Operations Manual,				
	• •	for Pharmaceutical Service				
		g-Term Care, published by				
		alth and Human Services,				
	· · · · · · · · · · · · · · · · · · ·	g Administration, April 1992.				
		rporated by reference. It is				
		•				
	_	Minitex interlibrary loan				
		ect to frequent change.				
	B. The pharmacis					
	_	ector of nursing services				
		sician, and these reports				
	must be acted upon b					
	· ·	ner, if indicated by the				
		oses of this part, "acted				
	upon" means the acco	eptance or rejection of the				
		or initialing by the director				
	of nursing services ar	nd the attending physician.				
	C. If the attending	g physician does not concur				
	with the pharmacist's	recommendation, or does				
	not provide adequate	justification, and the				
		he resident's quality of life is				
	•	ted, the pharmacist must				
	_	medical director for review				
	if the medical director					
		ical director determines that				
	• •					
		an does not have adequate				
		der and if the attending				
		ange the order, the matter				
	must be referred for re					
		rance committee required				
		the attending physician is				
	the medical director,	the consulting pharmacist				
	must refer the matter	directly to the quality				
	assessment and assu					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU COMPLE	
		00758	B. WING		11/08	3/2013
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA			
ANGELS	CARE CENTER		H DOW STREE FALLS, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
21530	Continued From page	e 32	21530			
	by: Based on interview at failed to ensure the condition interview at failed to ensure the condition interview at failed to ensure the condition interview at failed to ensure the condition interview at failed interview at failed to ensure the condition interview at failed to ensure the condition interview at failed to ensure the condition interview at failed to ensure the condition interview at failed to ensure the condition interview at failed to ensure the condition interview at failed to ensure the condition interview at failed to ensure the condition interview at failed to ensure the condition interview at failed to ensure the condition interview at failed to ensure the condition interview at failed to ensure the condition interview at failed to ensure the condition interview at failed to ensure the condition of the condition interview at failed to ensure the condition interview at failed to ensure the condition interview at fail to ensure the condition interview at fail to ensure the condition interview at fail to ensure the condition interview at fail to ensure the condition interview at fail to ensure the condition at fail to ensure the condition interview at fail to ensure the condition	s and reported them to the d physician for use of interventions before the J pain medications for 1 of 5 siled to assess for sleep residents (R8) reviewed for ions. ed (PRN) pain medications ne) without first attempting measures. R8 received ration (Trazodone) for ng assessed for sleep				
	chronic pain. The qua (MDS) dated 8/20/13 sleeping, received so received PRN medica non-medication interv pain and pain intensit	ed but not limited to posis, depressive disorder, arterly Minimum Data Set i, indicated R8 had no trouble heduled pain medication, ation, received rentions for pain, frequent y score of 10. R8's brief atus (BIMS) had been 9 out d indicated moderate				
	dated 10/30/13, revea 5 milligrams (mg) eve breakthrough pain, Ty	current physician orders aled an order for oxycodone ery six hours PRN for ylenol 650 mg every four nd Trazodone 50 mg at				

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Minnesota Department of Health

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
			A. BOILDING		
		00758	B. WING		11/08/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
ANGELS	CARE CENTER	300 NORT	TH DOW STREE	т	
ANOLLO	SAIRE SEITTER	CANNON	FALLS, MN 55	009	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
21530	Continued From page	: 33	21530		
	bedtime for depression	n with insomnia.			
	9/24/13, identified pro and directed nurses to interventions such as repositioning, distract for interrupted sleep a encourage activities a limit caffeine intake at quiet sleep environme and use of antidepreshad not been address. During review of R8's record and progress record and pr	warm packs, cool packs, ion techniques PRN. At risk and directed staff to and activeness during day, fer three p.m. and provide ent. Diagnosis of insomnia sant medication for sleep sed on the care plan. medication administration notes of PRN medication is the following had been of 10/4/13 through 10/31/13: a total of four doses of PRN mentation of interventions attempted and two doses of PRN potentiation of interventions attempted for one of two doses. In the solution of interventions attempted for one of two doses of documentation of interventions attempted for one of two doses and ycodone with no pharmacological end for three of four doses.			

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00758 B. WING 11/08/	3/2013
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
ANGELS CARE CENTER 300 NORTH DOW STREET CANNON FALLS, MN 55009	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530 Continued From page 34 21530	
During interview on 11/8/13, at 10:38 a.m., RN-C stated should offer repositioning at minimum for non-pharmacological intervention prior to giving PRN pain medication. RN-C verified not charting non-pharmacological interventions. During interview on 11/8/13, at 11:07 a.m., director of nursing stated she expected sleep assessment to be done when receiving medication for sleep and non-pharmacological interventions to be thred prior to administering PRN pain medication and to document the non-pharmacological interventions. During interview on 11/8/13, at 1:03 p.m., facility consulting pharmacist stated expected sleep to be done if resident not able to sleep and when reviewing charts routinely does not look for non-pharmacological interventions tried before giving PRN pain medication. Document review of facility policy Medication Regimen Review dated 12/107, read "Procedure: 3. Facility should independently review each resident''s medical chart and with Interdisciplinary Care Team members, resident or Responsible Party, as needed." SUGGESTED METHOD OF CORRECTION: The director of nursing and pharmacological interventions before use of as needed medications, educate staff, and ensure the findings are reported to the director of nursing and physician. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		00758	B. WING		11/08/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		300 NOR	TH DOW STREE	T	
ANGELS (CARE CENTER	CANNON	FALLS, MN 55	009	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION)N (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
21535	MN Rule4658.1315 S Drug Usage; General	Subp.1 ABCD Unnecessary	21535		
	must be free from unrunnecessary drug is a	, ,			
	therapy; B. for excessive of	duration; ate indications for its use; or			
	D. in the present which indicate the do	the of adverse consequences se should be reduced or			
		g regimen review required in			
	with provisions in the	nursing home must comply Interpretive Guidelines for ulations, title 42, section			
	483.25 (1) found in A	ppendix P of the State Suidance to Surveyors for			
	Long-Term Care Faci	lities, published by the and Human Services,			
	This standard is incor	g Administration, April 1992. porated by reference. It is			
	system and the State	Minitex interlibrary loan Law Library. It is not			
	subject to frequent ch	ange.			
	This MN Requiremen by:	t is not met as evidenced			
	Based on interview at failed to ensure use of	nd record review, the facility If non-pharmacological In attempted before the			
	administration of as n medications and pain	eeded antianxiety medications for 2 of 5			
		nd failed to assess for sleep residents (R8) reviewed for ions.			
	Findings include: R8	received as needed (PRN)			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	` '	CONSTRUCTION	(X3) DATE SU COMPLE	
		00758	B. WING		11/0	8/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
ANGELS	CARE CENTER		H DOW STREE FALLS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
21535	first attempting non-p R8 received antidepre (Trazodone) for inson for sleep quality. R8 had been admitted diagnoses that includ dementia, osteoarthro chronic pain. The qua (MDS) dated 8/20/13, sleeping, received sci received PRN medica non-medication interv pain and pain intensit interview of mental st of 15 on the MDS and cognitive impairment. During review of R8's dated 10/30/13, revea 5 milligrams (mg) eve breakthrough pain, Ty hours PRN for pain an bedtime for depression During review of R8's 9/24/13, identified pro and directed nurses to non-pharmacological packs, cool packs, re techniques PRN. At ri directed staff to encor activeness during day three p.m. and provid Diagnosis of insomnia medication for sleep if the care plan.	enol and oxycodone) without harmacological measures. essant medication innia without being assessed do on 2/18/13. R8 had ed but not limited to osis, depressive disorder, indicated R8 had no trouble heduled pain medication, ation, received rentions for pain, frequent by score of 10. R8's brief atus (BIMS) had been 9 out dindicated moderate dindicated moderate current physician orders alled an order for oxycodone bry six hours PRN for plenol 650 mg every four and Trazodone 50 mg at on with insomnia. Care plan review date oblem of impaired comfort of offer non-medication (or interventions such as warm positioning, distraction isk for interrupted sleep and	21535			

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WIIIIIICOCI	a Department of Fleatti					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVE	Υ
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
				_		
			B. WING			
		00758	D. WING		11/08/20	13
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		300 NORTI	H DOW STREE	· :T		
ANGELS (CARE CENTER		ALLS, MN 55			
		CANNON	ALLS, WIN 55	T		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI		MPLETE DATE
IAG	112002111011110111		IAG	DEFICIENCY)		
21535	Continued From page	e 37	21535			
	rooard and progress r	notes of DDN modication				
	. •	notes of PRN medication				
		s the following had been				
		of 10/4/13 through 10/31/13:				
		a total of four doses of PRN				
	Tylenol with no docun					
		interventions attempted				
	prior to administration	and two doses of PRN				
	oxycodone with no do	ocumentation of				
	non-pharmacological	interventions attempted				
	prior to administration	for one of two doses.				
	Review from the date	s of 11/1/13 through				
		ved a total of two doses of				
	PRN Tylenol with no	documentation of				
		interventions attempted				
		for one of two doses and				
	four doses of PRN ox					
	documentation of non					
		· ·				
	interventions attempte	ed for three of four doses.				
	During interview on 1	1/7/12 at 0:20 a m				
	During interview on 1					
	• • •)-C stated should monitor				
		gnosis of insomnia and				
		started for sleep. RN-C				
	•	itoring had been done for				
	R8.					
	•	1/8/13, at 10:38 a.m., RN-C				
		positioning at minimum for				
	non-pharmacological	intervention prior to giving				
		. RN-C verified not charting				
	non-pharmacological					
	During interview on 1	1/8/13, at 11:07 a.m.,				
		ated she expected sleep				
	assessment to be dor					
		and non-pharmacological				
		ed prior to administering				
		· ·				
	PRN pain medication					
	non-pharmacological	interventions.	1			

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE SUR COMPLETE			
		00758	B. WING		11	/08/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE		
ANGELS	CARE CENTER		H DOW STREET FALLS, MN 550			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21535	AND MANAGEMENT It is the policy for Voluthat all residents have pain assessment and residents will be evaluthistory of pain for the quarterly, with a significant with new onset of potential particular and of the staff interviews and of the staff interviews and of the staff interviews and of the staff interviews and of the staff interviews and of the staff interviews and of the staff interviews and of the staff interviews and of the staff interviews and of the staff interviews and of the staff interviews and the staff interviews and request staff interview and request staff interview and request staff interviews and restles solution 2 mg/ml give thours as needed for a staff interview and restless antianxiety medication lacked directions relations and restless antianxiety medication lacked directions to be attempted to the staff interview of alteration interview identified as contact and the staff interview and restless antianxiety medication lacked directions relations to be attempted to the staff interview and restless antianxiety medication lacked directions to be attempted to the staff interview and restless antianxiety medication dementia with behaviour were identified as contact and restless antianxiety medication lacked directions relations to be attempted to the staff interview and restless antianxiety medication lacked directions relations to be attempted to the staff interview and restless antianxiety medication lacked directions relations to be attempted to the staff interview and restless antianxiety medication lacked directions relations to the staff interview and restless antianxiety medication lacked directions relations to the staff interview and restless antianxiety medication lacked directions relations and restless antianxiety medication lacked directions relations and restless antianxiety medication lacked directions relations and restless antianxiety medication lacked directions relations and restless antianxiety medication lacked directions relations and restless antianxiety medication lacke	acility PAIN EVALUATION dated 2010, read "POLICY inteers of America (VOA) e the right for appropriate pain management. All lated for indicators or a MDS 3.0 on admission, ficant change in status, and ential pain or discomfort. through resident interviews, beervations." ded from facility a policy for a provided. dety medications as needed in of the use of interventions. demory care unit and had ed Alzheimer 's disease and oral disturbances. s order for Ativan 0.5 mg h every 4 hours as needed ssness and lorazepam 0.5 mg by mouth every 4 lagitation and restlessness. lacked symptoms of ness for which the n was to be given and led to non-pharmacological lempted first. ded 11/7/13 identified a in thought process related to lors. The target behaviors of usion, looking for "dad", lows at times, may refuse	21535			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION		E SURVEY PLETED
		00758	B. WING		11	/08/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
ANGELS (CARE CENTER		RTH DOW STREET N FALLS, MN 5500	9		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21535	accusatory statemen paranoia, tearfulness staff, delusion The ir non-pharmacological using the as needed interventions listed in re-approach, 1:1, red validation PRN, allow feeling, frustrations, as In October R56 recei Ativan. Re view of the and nursing progress reveal the behavior of interventions used proposed and paranti-anxiety medication. During an interview of Clinical Manager (CN document non-pharmathe progress notes.) SUGGESTED METH The director of nursing evaluate the use of nursing evaluate the use of these with the use of these	s of being afraid, anxiety, ts towards others, agitation, physical abuse towards otherventions did not identify interventions to try prior to medication. Additional the care plan included: lirection, reassurance, resident time to express her and sadness. Ved 4 doses of as needed the behavior documentation is notes for October did not the ron-pharmacological ion to the as needed ons. In 11/8/13 at 1:20 p.m. In 11/8/13 at 1:20 p.m. In 10D OF CORRECTION: The or designee could on-pharmacological interventions on the same of the	21535			
21630	MN Rule 4658.1350 Medications; Destruction Subp. 2. Destruction		21630			
	A. Unused portion	ons of controlled substances ling home after death or				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		, ,	E SURVEY PLETED
			D. MING			
		00758	B. WING		11	/08/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	, ZIP CODE		
ANGELO	CARE CENTER	300 NOR	TH DOW STREET			
ANGELS	CARE CENTER	CANNON	FALLS, MN 5500	9		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21630	Continued From page	e 40	21630			
	prescribed, or any condiscontinued permand manner recommende or the consultant pharmacist must furni instructions and forms kept on file in the nurse. B. Unused portion drugs remaining in the death or discharge of were prescribed or an discontinued permand according to part 680 be returned to the pharmacist forms of the pharmacist forms. The prescription of the prescription of the pharmacist forms of the pharmacist forms of the pharmacist forms. The prescription of the prescription	ently must be destroyed in a d by the Board of Pharmacy rmacist. The board or the ish the necessary s, a copy of which must be sing home for two years. In so of other prescription enursing home after the the resident for whom they by prescriptions ently, must be destroyed 100.6500, subpart 3, or must parmacy according to part				
	by: Based on observation documentation review document destruction narcotic used for mode of 3 medication rooms encourage diversion of residents and/or visitor Findings include: Dur on 11/8/13, at 8:40 a. (LPN)-C indicated the fentanyl patches had then placed into the scontainer is a term for that is predominantly	w, the facility failed to of fentanyl patches (a lerate to severe pain) for 3 s. This practice could of pain medications by staff,				

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X3) DATE SURVEY		
AND PLAN (ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING: _		COMPLE	TED
			D WING			
		00758	B. WING		11/08	3/2013
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
ANGELS CARE CENTER CANNON F.			TH DOW STREE			
0/0.15	STIMMADY ST		<u> </u>	PROVIDER'S PLAN OF CORRECTION	N	0/5)
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
21630	Continued From page	e 41	21630			
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL					

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WIIIIIICSOL	a Department of Fleatt	I				
	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (AN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLE	= I ED
			1			
		00758	B. WING		11/0	8/2013
NAME OF D	20//050 00 01/001/50	OTDEET AS		TE 7/D 00DE		
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
ANGELS CARE CENTER			TH DOW STREE			
		CANNON	FALLS, MN 55	009		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETE DATE
IAG		,	IAG	DEFICIENCY)		
04005	0 " 15	10	04005			
21685	Continued From page	: 42	21685			
21685	MN Rule 4658.1415 S	Subp. 2 Plant	21685			
	Housekeeping, Opera	ition, & Maintenance				
		nt. The physical plant,				
	_	, ceilings, all furnishings,				
	systems, and equipme					
	_	ood repair and operation				
		ilth, comfort, safety, and				
	~	dents according to a written				
	routine maintenance a	and repair program.				
	This MN Poquiromon	t is not mot as avidanced				
	by:	t is not met as evidenced				
	•	and interview, the facility				
		sanitary environment in the				
		as stored, cooked and				
	served to 57 of 57 res					
	00.700 10 07 0.07 100	nacine in the lacinty.				
	Findings include:					
	During initial tour of ki	itchen on 11/4/13, at 9:10				
	_	ctor, observation revealed				l
	•	located behind the ovens				
		ase spots and one of the				
		yer of food build up. Dietary				
		ens get cleaned once a				
		nis cleaning if there are food				
	spills they should be o					
	Sp a troj oriodia bo c					
	During interview on 1	1/7/13, at 11:22 a.m., dietary				
		d no policy regarding the				
		edule of kitchen environment				
	which includes applia					
	0110050555	op of oopper				
		OD OF CORRECTION:				
		ıld in-service employees				
	_	rens and kitchen equipment				
	on the need to keen it	clean and canitary	1	1		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00758	B. WING		11/08/2013
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	E. ZIP CODE	1
			TH DOW STREE		
ANGELS CARE CENTER		FALLS, MN 550	09		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
21685	Continued From page	e 43	21685		
	TIME PERIOD FOR CORRECTION: Twenty One (21) days.				
21805	MN St. Statute 144.69 Residents of HC Fac.		21805		
	Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility.				
	by: Based on observation review, the facility fail dining experience in t Lane) for 8 of 16 resic R37, R73, R82 and R	t is not met as evidenced i, interview, and document ed to promote a dignified he secured unit (Memory dents (R66, R63, R65, R38, 56) observed during a meal.			
	while other residents independently and whas not checked for v	of was not assisted to eat at the table ate nen assisted to eat the food warmth as it sat in the food of for a total of 37 minutes.			
	dementia, hallucinatio	e, esophageal reflux, legal			
	8/12/2013 identified R	Data Set assessment dated 866 as severely cognitively I extensive assist of one for			

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On 11/4/2013 12:12 p.m., the food cart arrived in

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	a Department of Fleatt		1		т —	
	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	ETED
		00759	B. WING		44/0	0/2042
		00758	1		11/0	8/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		300 NORT	H DOW STREE	:T		
ANGELS CARE CENTER			FALLS, MN 55			
			TALLO, MIN 33			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
1710	REGULATORY OR LSC IDENTIFYING INFORMATION)			DEFICIENCY)		
21805	Continued From page	e 44	21805			
	the unit from kitchen	At 12:35 p.m., R66 received				
		nad been uncovered. There				
		dents at this table and all				
	_	soon as the meal was				
	-	atched the others eat until				
		tic covered piece of bread				
	_	on it as the nurse had not				
	-	rom the sandwich when				
		R66. After the nurse had				
		om the sandwich R66 make				
	•	ependently. At 12:42 p.m.,				
		A sat next to R66 and began				
		However, the food that had				
	been delivered thirty r	minutes ago and sat				
	uncovered for seven i	minutes was not warmed for				
	the resident.					
	On 11/6/2013, food tra	ays arrived at 11:55 a.m. in				
	the unit, R66 again re	ceived a tray uncovered at				
	12:15 p.m. and made	no attempt to eat and soon				
	fell asleep in the whee	elchair. No staff				
	encouraged or assiste	ed R66 to eat until nursing				
	assistant (NA)-F sat r	next to R66 at 12:43 p.m.				
		the table uncovered for 28				
		n in the food cart for 20				
		set in front of R66. On				
		12:43 in regards to the food				
		that she felt the food was				
		no attempt to test the food				
	for temperature or wa	•				
	ioi temperature or wa					
	R63 was not clied to	eat, not to eat cake with				
		a fork and foods were not				
		after setting for 38 minutes				
		•				
		d was delivered to the unit				
	and when R63 began					
		ith diagnoses this included				
	but not limited to: ser					
	A quarterly MDS date					
	resident as severely of	cognitively impaired and				

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	a Department of Fleatt		1		ı	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	=1ED
		00758	B. WING		11/0	8/2013
		00.00			11/0	0/2010
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ANGELS	CARE CENTER	300 NORT	H DOW STREE	T		
ANGELS	DAKE CENTER	CANNON	FALLS, MN 55	009		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	١	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	RIATE	DATE
				DEI IGIENGT)		
21805	Continued From page	e 45	21805			
		and cueing after set up of				
	meal.					
		5 a.m., the food cart had				
		en. The menu was Tater Tot				
		nd chocolate chip dessert.				
		ceived a meal tray that had				
	been uncovered. R63					
		e the food was placed in				
		awoke at 12:33 p.m. R63				
		ted drinking some after this				
		ce of cake unto the plate				
	_	e with her fingers. There was				
	_	ourage R63 to eat the meal				
		nt of her or to use a fork to				
	eat the cake. R63 beg	gan to eat the foods after 38				
	minutes when it was	delivered to the unit. No staff				
	checked the foods to	determine if the food was				
		began to eat the foods.				
	During the entire mea	al service for R63 there was				
	a nursing assistant se	eated at the same table				
	helping R37 to eat the	eir meal.				
	R65 had been observ	red to not wear lower				
	denture during meal a	and no staff attempted to				
	encourage her to do	so. R65 held the denture in				
	her hand while attemp	oting to use fork with the				
	same hand.					
	R65 had diagnoses w	hich included: senile				
	dementia, altered me	ntal status and depressive				
	disorder.					
	R65's annual MDS assessment dated 10/11/2013 identified R65 as severely cognitively impaired					
	and required supervis	sion and cueing of one staff				
	for eating.	-				
	_					
	On 11/6/2013 at 11:55	5 a.m., the food cart arrived				
		nemory lane. The menu				
	was Tater tot Hotdish					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE	SURVEY
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMP	LETED
		00758	B. WING		11/	/08/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	ODRESS, CITY, STA	TE, ZIP CODE		
ANGELO	DARE CENTER	300 NOR	TH DOW STREE	Т		
ANGELS	CARE CENTER	CANNON	FALLS, MN 550	009		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21805	Continued From page	e 46	21805			
	chocolate chip desser received a food tray or resident used a fork a left hand. The reside clutching their lower of while holding the fork R65 started eating the 12:21 p.m., R65 use of the cake she just p placed it back in the bear was done eating and dentures which she houring the entire mean encouraged her to us the meal nor had they fork to eat the foods p	rt. At 12:01 p.m. R65 of regular textured food. The and started to eat with the nt was observed to be dentures in the left hand to eat. At 12:12 p.m., e cake using her fingers. At her fingers to remove some ut into her mouth and bowl. At 12:27 p.m., R65 was still holding the bottom ad during the entire meal. al for R65 no staff e her bottom denture to eat of encouraged her to use the brovided. R65 was not noted th coughing while eating the				
	nurse (LPN)-D was in not using the bottom of meal on 11/6/13 at not would take dentures of when the resident wat is to encourage R65 the eating. R65 was observable holding denture informing LPN-D of RLPN-D approached Redenture back in her made no attempt to reserve of the meal. R38 was not assisted manner. A quarterly minimum 10/6/2013 identified recognitively impaired as	a.m., a licensed practical nterviewed regarding R65 's dentures while eating the bon. LPN-D indicated R65 but of mouth and put them in nted. LPN-D said that staff to wear dentures while erved at 8:30 to be eating in her left hand. After 65 holding onto denture 165 and asked her put her mouth. R65 nodded yes and e in R65 's mouth and R65 emove the denture for the during dining in a timely data set assessment dated esident as severely and required limited assist of The resident had diagnoses				

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	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SI COMPLE	
		00758	B. WING		11/0	8/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ANGELS (CARE CENTER		H DOW STREE			
		CANNON F	ALLS, MN 55	009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
21805	Continued From page	e 47	21805			
2.000	which included: Alzhe and depression. On 11/4/2013 at 12:12 on memory lane unit that 12:25 p.m., R 38 which was a summer and the restriction of the satisfied o	eimer's dementia, aphasia, 2 p.m., the food cart arrived from the kitchen. It is given a tray of food sident started playing with the resident made no attempt sisted the resident. At 12:42 (NM)-A sat down by R38 dent to eat. The resident's eart for 13 minutes and then the resident is series at the resident is series at the resident is series and then the resident is series at the resident is series and then the resident is series at the resident is serie				
	R37 was not consistently cued nor assisted to eat until 21 minutes after food plate had been put in front of her and staff sat to assist her to eat. Also the food had not been checked for temperature before NA-C began assisting her to eat.					
	resident as moderate					
	in the memory lane up of food uncovered at observed to be asleep food arrived. NA-C we couple of times, but the as soon as NA-C left. next to R37 and begat was 33 minutes after unit and 21 minutes at	5 a.m., the food cart arrived nit. R37 received a meal tray 12:07 p.m. R37 was in the wheelchair when the rent over to cue R37 to eat a ne resident would doze off At 12:28 p.m., NA-C sat in to assist R37 to eat. This the food trays arrived in the fter R37 's food was placed her. NA-C had not checked				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE COMF	SURVEY
		00758	B. WING		11/	/08/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE		
ANGELS	CARE CENTER	300 NOR	TH DOW STREET			
		CANNON	FALLS, MN 5500	9		_
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21805	Continued From page	÷ 48	21805			
	the food for temperate to warm the foods.	ures and made no attempt				
	R73 was not assisted dining.	in a timely manner during				
	on the memory lane u At 12:42 p.m., R73 ha of her and it was unco in the food cart for thin	2 p.m., the food cart arrived unit from the kitchen. ad a tray of food put in front overed. The food had been rty minutes and had not perature before serving to				
	12:12 p.m. until 12:45 wheelchair with lap be around the dining roo eating or waiting to be singing loudly and for she was assisted to a eat her meal at 12/42 was yelling at R73 to R56 would add to the Hello! " then R56 use loudly on the table. The interventions for any of from residents making disruptive dining experesidents living on the the privacy of their be at the start of the meaning to be a single proper sidents.	addy on wheeling self m as other residents were e assisted to eat. R73 was long periods of time until table and encouraged to p.m. During this time R82 " Shut up! Shut up! " Then yelling by saying, " Hello! ed her spoon to pound it here were no staff of these disruptive behaviors g an unpleasant and erience for 16 of the 17 e unit as one resident at in droom. It was also observed all that no resident had their hough several had used				
	regarding dining obse	p.m. and again on ., LPN-D was interviewed rvations on 11/4/13 at noon. een normal for some of the				

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STATEMENT	OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00758	B. WING		11/08/2013	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
ANGELS CARE CENTER			H DOW STREE			
0/0.15	STIMMADV ST.	ATEMENT OF DEFICIENCIES	FALLS, MN 55	PROVIDER'S PLAN OF CORRECTION	l over	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLE	
21805	Continued From page	e 49	21805			
	residents to wait to ea	at because of the short				
		that they usually staffed one				
		one nurse during the day				
		who needed quite a bit of ents are assisted to eat as				
		around to them and the food				
	, ,	d for the residents who sat a				
		e assisted to eat. LPN-D				
		sn ' t always able to cue the				
	_	uld have been to eat their monitor behaviors closely				
		e it was too busy during the				
		t residents assisted to eat.				
	SUGGESTED METH	OD OF CORRECTION:				
		ector or nursing or designee				
	could provide staff ed	ucation related to dignified				
	dining services and m	nonitor for compliance				
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty One				

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