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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ETLH

Facility ID: 00758

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245304**
2.STATE VENDOR OR MEDICAID NO.
(L2) **908108900**

3. NAME AND ADDRESS OF FACILITY
(L3) **ANGELS CARE CENTER**
(L4) **300 NORTH DOW STREET**
(L5) **CANNON FALLS, MN** (L6) **55009**

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **2/13/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **89** (L18)

13.Total Certified Beds **89** (L17)

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A*** (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	89			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Marietta Lee, HFE NE II 03/13/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 05/16/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/28/2014
(L33)

DETERMINATION APPROVAL

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 February16, 2014, is rescinded.
(42 CFR 488.417 (b))

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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:

• 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

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

Enclosure

cc: Licensing and Certification File

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00758	A. Building B. Wing	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 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
ID Prefix **20895** Reg. # **MN Rule 4658.0525 Subp.** LSC	Correction Completed **02/13/2014**	ID Prefix **21015** Reg. # **MN Rule 4658.0610 Subp.** LSC	Correction Completed **02/13/2014**	ID Prefix **21980** Reg. # **MN St. Statute 626.557 Sul** LSC	Correction Completed **02/13/2014**
ID Prefix **21985** Reg. # **MN St. Statute 626.557 Sul** LSC	Correction Completed **02/13/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GN/KFD	03/13/2014	15425	02/13/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
11/8/2013				

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.

Sincerely,

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

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245304	A. Building B. Wing	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** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **02/13/2014**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **02/13/2014**	ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **02/13/2014**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **02/13/2014**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **02/13/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By _____ **State Agency**	**Reviewed By** GN/KFD	**Date:** 03/13/2014	**Signature of Surveyor:** 15425	**Date:** 02/13/2014
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**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?** **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ETLH

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00758

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245304**
2.STATE VENDOR OR MEDICAID NO.
(L2) **908108900**

3. NAME AND ADDRESS OF FACILITY
(L3) **ANGELS CARE CENTER**
(L4) **300 NORTH DOW STREET**
(L5) **CANNON FALLS, MN** (L6) **55009**

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/03/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **89** (L18)

13.Total Certified Beds **89** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	89			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Marietta Lee HFE NE II 12/24/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 05/16/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/28/2014
(L33)

DETERMINATION APPROVAL

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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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.

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:

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

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.

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00758	A. Building B. Wing	1/3/2014

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 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
ID Prefix **20565** Reg. # **MN Rule 4658.0405 Subp.** LSC	Correction Completed **12/18/2013**	ID Prefix **20570** Reg. # **MN Rule 4658.0405 Subp.** LSC	Correction Completed **12/18/2013**	ID Prefix **20800** Reg. # **MN Rule 4658.0510 Subp.** LSC	Correction Completed **12/18/2013**
ID Prefix **20920** Reg. # **MN Rule 4658.0525 Subp.** LSC	Correction Completed **12/18/2013**	ID Prefix **21375** Reg. # **MN Rule 4658.0800 Subp.** LSC	Correction Completed **12/18/2013**	ID Prefix **21426** Reg. # **MN St. Statute 144A.04 Su** LSC	Correction Completed **12/18/2013**
ID Prefix **21530** Reg. # **MN Rule 4658.1310 A.B.C** LSC	Correction Completed **12/18/2013**	ID Prefix **21535** Reg. # **MN Rule4658.1315 Subp.1** LSC	Correction Completed **12/18/2013**	ID Prefix **21630** Reg. # **MN Rule 4658.1350 Subp.** LSC	Correction Completed **12/18/2013**
ID Prefix **21680** Reg. # **MN Rule 4658.1415 Subp.** LSC	Correction Completed **12/18/2013**	ID Prefix **21685** Reg. # **MN Rule 4658.1415 Subp.** LSC	Correction Completed **12/18/2013**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GN/AK	01/24/2014	19694	01/03/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**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? **YES** **NO**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245304	A. Building B. Wing	1/3/2014

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 **F0241** Reg. # **483.15(a)** LSC	Correction Completed **12/18/2013**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **12/18/2013**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **12/18/2013**
ID Prefix **F0285** Reg. # **483.20(m), 483.20(e)** LSC	Correction Completed **12/18/2013**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **12/18/2013**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **12/18/2013**
ID Prefix **F0353** Reg. # **483.30(a)** LSC	Correction Completed **12/18/2013**	ID Prefix **F0373** Reg. # **483.35(h)** LSC	Correction Completed **12/18/2013**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **12/18/2013**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **12/18/2013**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **12/18/2013**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **12/18/2013**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GN/AK	01/24/2014	19694	01/03/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
11/8/2013			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245304	A. Building B. Wing **01 - MAIN BUILDING 01**	1/17/2014

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0067	**01/08/2014**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/AK	01/24/2014	25822	01/17/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
11/5/2013	

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.

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

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	R 01/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS CARE CENTER	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS During a post certification revisit to the facility on January 2, 3, 2014 the facility was found to be uncorrected for the following deficiencies: F318, F323, and F371. New deficiencies were cited at F225 and F226. A complaint investigation/s had been completed at the time of the standard recertification survey on 11/08/13 and during the post certification revisit completed on January 2, 3, 2014 the complaint H5304018 had been corrected at F241, F312, F353.	{F 000}		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225	**F225** The facility will ensure that there is an abuse prevention plan in place and that all alleged violations are fully investigated and prevent the potential for further abuse based on the facility policy and procedure. Resident #6 has had incidents of verbal abuse by a family member reported, investigated and action taken per facility policy. Residents care plan was reviewed and updated. 2/5/14 SPN	

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

Administrator 2-3-14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	R 01/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS CARE CENTER	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 1 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to immediately report allegations of verbal abuse to the executive director/administrator nor to the designated state agency immediately nor complete a thurough investigation and implement interventions to prevent further inicdenets from reoccuring and protect the resident while the investigation was conducted for 1 of 1 resident (R6) who was reviewed for allegations of abuse. This had the potential to affect all 58 residents in the facility. Findings include: R6 received continued verbal mistreatment without thorough investigation and interventions in place to prevent further verbal mistreatment by family member. During observations on 1/3/14, at 2:10 p.m., surveyor heard family (F)-A of R6 ' s in the lobby loudly state, " Jesus woman shut up " to R6.	F 225	Facility policy and procedure was reviewed and appropriate. All staff will be educated on the facility Resident Protection policy. Facility has implemented a tracking log of incidents to monitor proper documentation and reporting. The facility Social Worker or designee will interview 3 residents weekly to see if they have concerns and ensure follow-up is completed and also monitor that the procedure is being followed. Administrator or designee will conduct weekly audits of at least 3 staff to determine knowledge of the facility's policy and procedure for reporting and investigation of resident incidents. Immediate re-education of staff will be completed if problems or inconsistencies are found. Results of audits will be communicated to the QA	2/8/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	R 01/03/2014

FEB 5 2014
MN Dept of Health
Rochester

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS CARE CENTER	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 2 Observations at that time revealed R6 sat in a wheelchair in the lobby and three staff members were also located in the lobby. Surveyor immediately reported the incident to the nurse coordinator who was in charge of the residents on 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. R6 was identified on the facility Admission Record Resident Information form dated 8/26/10, to have diagnosis that included diabetes mellitus and congestive heart failure. R6 was identified by the facility on the quarterly Minimum Data Set (MDS); an assessment dated 10/23/13, to have intact cognition, required extensive assistance of one staff for activities of daily living, and had lower extremity range of motion functional limitation on both sides. During interview on 1/3/14, at 2:25 p.m., the executive director and SW verified they were aware of F-A 's verbal behavior toward R6. Although executive director and SW stated they had talked with R6 and F-A in the past, they verified the facility lacked evidence of a thorough investigation of the behaviors and also verified they had not reported the verbal behaviors to the designated state agency before determining it	F 225	committee and action plans developed as needed. The facility will be substantial compliance with the standard indicated by 2/8/14.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	R 01/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS CARE CENTER	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 3 had not been considered verbal abuse. During interview on 1/3/14, at 3:00 p.m., executive director stated she expected staff to report incidents of alleged verbal abuse to her and to complete an incident report. Executive director verified there have been no incidents reported to her of verbal abuse in the facility and no incident reports of verbal abuse involving R6 and F-A. During interview on 1/3/14, at 3:05 p.m., R6 stated she was not "concerned" about verbal mistreatment, but that she would be " more concerned about physical abuse." R6 stated F-A had not hit her. R6 stated she had lived at the facility for six years and F-A visited her every day. R6 stated F-A yelled at her a lot but that she lets it "go in one ear and out the other." R6 stated verbal abuse did not "scare " her but that "doesn't scare her but physical abuse" did scare her. R6 stated F-A often "angers a lot." R6 stated although she had not done so, if F-A was "verbal" with her, she would tell family member to go home and she would report to the nurses to watch for the return of F-A. R6 stated she felt safe in the facility. Facility staff interviews included the following: During interview on 1/3/14, at 2:55 p.m., receptionist-A (R-A) stated she was aware of F-A ' s behavior. R-A stated most of the time F-A spoke to R6 in a " disrespectful " tone, also F-A yells at R6 "You never listen to me." R-A stated she usually reported this behavior to social worker or registered nurse manager or executive director, so " someone can deal with it." R-A stated she would call vulnerable adult number if	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	R 01/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 225	Continued From page 4 there were no supervisor to notify. R-A stated social services or director of nursing had not given any recommendations to R-A for what to do when F-A treats R6 disrespectfully except to report the incident to nurse, director of nursing or executive director. During interview on 1/3/14, at 3:05 p.m., housekeeper-A (HSK-A) stated they had been aware of F-A ' s behavior of loud, rude and nasty behavior towards R6. HSK-A stated the behavior had occurred for the past 2 to 3 weeks and that HSK-A did not get involved. HSK-A stated sometimes R6 talked back to F-A during F-A yelling. During interview on 1/3/14, at 3:08 p.m., registered nurse (RN)-C stated F-A, alleged verbal behavior was just their personality and that sometimes R6 would talk back to family member. RN-C stated if she did hear something she felt was abusive from F-A towards R6, RN-C would report to facility social worker or the evening supervisor, since the family member visited in the evenings. Document review of facility incident report forms from 12/18/13 to 1/2/14, revealed no reports of alleged verbal abuse towards R6. Document review of R6 progress notes dated 10/3/13 to 1/1/14, revealed no evidence of incidents of verbal mistreatment by family member. Document review of R6 care plan dated 11/20/13, revealed focus resident was vulnerable to abuse by staff and/or other residents related to impaired physical mobility. Care plan goal was safety	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	R 01/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 225	Continued From page 5 would be protected through staff intervention. Interventions included to encourage resident to report to staff if resident felt threatened or bothered by other residents and/or staff. R6 care plan lacked interventions for continued verbal behaviors by family member. Document review of facility Resident Incident Process policy revised dated 7/13, revealed the following: Procedure: 1. Immediately upon witnessing or being notified of an accident, incident or altercation involving a resident, an investigation of the facts surrounding the incident is initiated. Any fall, injury of unknown or known origin, (including bruises and skin tears) medication errors, allegation of injury, allegation of abuse, neglect and/or maltreatment, self-abuse/suicide attempt, suspicious death of a resident, elopement (this includes allegations of resident to resident abuse and incidents of alleged financial exploitation) will be documented in the Risk Management Program of the EMR. 3. Follow all immediate reporting and notification procedures for mandated reporting and elder justice act for situations of alleged abuse/neglect, including immediate notification to the Executive Director. 5. The Executive Director, Director of Nursing and /or Social Service Director and IDT Designees ensures that appropriate follow-up, notifications, and investigation is completed with the incident, and documents the follow-up. 6. Staff are to implement interventions for safety to prevent reoccurrence. Document review of facility	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	R 01/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS CARE CENTER	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 6 Resident/client/participant Protection Policy and Procedure revised dated 12/12, directed staff the following: page 5: #2. Investigation: a. Upon receiving a complaint of alleged maltreatment, the ED (executive director), Director of Nursing/designee and Social services or designee will coordinate an investigation, which will include completion of witness statements. b. All parties involved including two of the following-staff, resident/client/participants or visitors, who were potentially involved, or observed the alleged incident are to be interviewed by ED, DON, Social services or designee. Statements should be written on the Witness Interview Form. Interviews should be conducted with 2 staff members present whenever possible/appropriate. f. Identify and implement appropriate interventions, i.e., increased 1:1, psychological consultation. h. The investigation and written findings are completed and reviewed with the Executive Director/or designated representative, and to other officials in accordance with state law. A plan for further action is determined with input from appropriate personnel. Completion of the Investigative Data Sheet will ensue to prevent further occurrences as specified per policy. k. The facility/service will investigate all alleged violations and will prevent further potential abuse while the investigation is in progress. Page 6: #4. Reporting Maltreatment of Individuals: a. Who must report suspected maltreatment of a resident/client/participant? Any employee,	F 225		

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F 225	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 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, written or gestured language toward a	F 225		

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F 225	Continued From page 8 vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening. 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 F-A had moved into the area. Executive director stated she was not aware of any incidents of F-A exhibiting verbal behaviors toward other residents. She stated F-A had "sworn" at staff one time that she was aware of and executive director immediately talked to F-A concerning this behavior. Executive director verified there was no documentation of this conversation with F-A. Executive director stated she talked with the "Ombudsman" one time "either the last week of November 2013 or first week of December 2013" in regards to F-A and R6 ' s situation. Executive director verified there was no documentation of this conversation either. Executive director stated the facility had no incident reports related to F-A ' s alleged verbal behaviors. Executive director stated the facility had not reported R6's alleged verbal abuse by F-A to the office of health facility (OHFC) as this behavior had been ongoing. Executive director verified the facility lacked a thorough investigation of the ongoing allegation of verbal abuse by F-A in regards to R6. Executive director than said that any allegation of abuse of any type is to be reported to her immediately.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written	F 226		

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F 226	Continued From page 9 policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement their Resident Incident Process and Resident/client/participant Protection Policy and Procedure which indicated allegations of abuse were to be immediately reported to the executive director, reported to the designated state agency, failed to initiate an investigation, and failed to implement interventions to protect 1 of 1 resident (R6) observed for verbal maltreatment. This had the potential to affect all 58 residents residing in the facility who were vulnerable to abuse due to staff failure to implement their policies. Findings include: R6 experienced on-going verbal mistreatment from a family (F)-A member for approximately eleven weeks without immediate executive director notification, without designated state agency notification, without thorough investigation, and without interventions in place to protect R6 from ongoing verbal mistreatment, according to facility vulnerable adult policies. Document review of facility Resident Incident Process policy revised dated 7/13, revealed the following: Procedure: 1. Immediately upon witnessing or being notified of an accident, incident or altercation involving a resident, an investigation of the facts	F 226	**F226** The facility will ensure that there is an abuse prevention plan in place and that all alleged violations are fully investigated and prevent the potential for further abuse based on the facility policy and procedure. Resident #6 has had incidents of verbal abuse by a family member reported, investigated and action taken per facility policy. Residents care plan was reviewed and updated. Facility policy and procedure was reviewed and appropriate. All staff will be educated on the facility Resident Protection policy. Facility has implemented a tracking log of incidents to monitor proper documentation and reporting. The facility Social Worker or designee will interview 3 residents weekly to see if they have concerns and ensure follow-up is completed	2/8/14

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F 226	Continued From page 10 surrounding the incident is initiated. Any fall, injury of unknown or known origin, (including bruises and skin tears) medication errors, allegation of injury, allegation of abuse, neglect and/or maltreatment, self abuse/suicide attempt, suspicious death of a resident, elopement (this includes allegations of resident to resident abuse and incidents of alleged financial exploitation) will be documented in the Risk Management Program of the EMR. 3. Follow all immediate reporting and notification procedures for mandated reporting and elder justice act for situations of alleged abuse/neglect, including immediate notification to the Executive Director. 5. The Executive Director, Director of Nursing and /or Social Service Director and IDT Designees ensures that appropriate follow-up, notifications, and investigation is completed with the incident, and documents the follow-up. 6. Staff are to implement interventions for safety to prevent reoccurrence. Document review of facility Resident/client/participant Protection Policy and Procedure revised dated 12/12, directed staff the following: page 5: #2. Investigation: a. Upon receiving a complaint of alleged maltreatment, the ED (executive director), Director of Nursing/designee and Social services or designee will coordinate an investigation, which will include completion of witness statements. b. All parties involved including two of the following-staff, resident/client/participants or visitors, who were potentially involved, or observed the alleged incident are to be	F 226	and also monitor that the procedure is being followed. Administrator or designee will conduct weekly audits of at least 3 staff to determine knowledge of the facility's policy and procedure for reporting and investigation of resident incidents. Immediate re-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 compliance with the standard indicated by 2/8/14.	

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F 226	Continued From page 11 interviewed by ED, DON, Social services or designee. Statements should be written on the Witness Interview Form. Interviews should be conducted with 2 staff members present whenever possible/appropriate. f. Identify and implement appropriate interventions, i.e., increased 1:1, psychological consultation. h. The investigation and written findings are completed and reviewed with the Executive Director/or designated representative, and to other officials in accordance with state law. A plan for further action is determined with input from appropriate personnel. Completion of the Investigative Data Sheet will ensue to prevent further occurrences as specified per policy. k. The facility/service will investigate all alleged violations and will prevent further potential abuse while the investigation is in progress. Page 6: #4. Reporting Maltreatment of Individuals: a. Who must report suspected maltreatment of a resident/client/participant? Any employee, 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	F 226		

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F 226	Continued From page 12 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, written or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening. During interview on 1/3/14, at 3:12 p.m., registered nurse-B (RN-B) stated was aware of R6 ' s family member ' s behavior. RN-B verified the family member talked loud, rude and nasty to other residents. RN-B stated the behavior had	F 226		

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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.	F 226		
{F 318} SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide range of motion (ROM) services for 4 of 4 residents (R4, R20, R10, R34) reviewed for ROM services. Findings include: R4 lacked range of motion services as recommended by physical therapy and occupational therapy. R4 was observed on 1/3/14 at 11:50 a.m. sitting in a wheelchair in room. R4 was noted to have	{F 318}	**F 318** Residents R4, R20, R10, and R34 identified in this statement of deficiency have been reassessed for services recommended by therapy, including ROM, and updates were made to the care plan and care card. Nursing staff was re-educated on 1/23/14 on following the resident's care plan/care card for all cares, including ROM and other services recommended by therapy and nursing and documentation of the services provided.	2/8/14

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{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 asked if received range of 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 binder also	{F 318}	The Nurse Managers have reviewed all residents on their units with recommendations from therapy for ROM or other services. Changes were made to the care plan and care card as needed. All residents not on skilled therapy will be assessed quarterly and with significant change for changes in ROM, in conjunction with the RAI process. The Nurse Managers have made and will maintain a list of all residents on their unit who are on a ROM or walking program or are receiving any other service recommended by therapy. The list will be reviewed at the weekly IDT Meeting. Resident's mobility needs will continue to be reviewed at care conferences. The list noted above will also be used at the Nursing Stations for documentation of services and charting. The Nurse Managers	

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{F 318}	Continued From page 15 had a picture guide labeled with R4's name with instructions for range of motion to lower extremities 5-10 repetitions daily and left upper extremities 10 repetitions daily signed by occupational therapy. When requested, no documentation related to provision of range of motion for R4 was provided. Nursing assistant NA-A was interviewed on 1/3/14 at 11:00 a.m. NA-A stated he was responsible for providing range of motion for R4, but had not done so because he did not have time to do so. R20 lacked range of motion services as recommended by the physical therapy and occupational therapy. On 1/3/13 at 11:15 a.m. R20 was observed sitting in a wheelchair. When asked R10 was unable to straighten out both hands. R20 stated that staff did not do range of motion. The care plan provided 1/3/14 identified diagnoses of multiple sclerosis, dementia, pain in soft tissues of limbs, muscle weakness, abnormal posture, stiffness of 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	{F 318}	and/or nurses are responsible for monitoring compliance. A new Therapy to Nursing Communication form has been developed and implemented to improve communication related to therapy recommended services. Nurse Managers/designee will do weekly audits on at least 3 residents on their unit who are on ROM or walking programs or are receiving any other service recommended by therapy to ensure appropriateness of services and compliance with policy and procedures. Results of the audits will be reviewed by the QA Committee and action plans developed as needed. Audit frequency will be reduced based on compliance and recommendations from the QA Committee.	

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{F 318}	Continued From page 16 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. The physical therapy discharge summary dated 1/31/13 indicated a lower extremity range of motion program had been developed. The restorative nursing program form signed by occupation therapy directed upper extremity passive range of motion 10 repetitions daily. The care plan had interventions dated 2/28/13 that directed assist of one for passive range of motion to left upper extremity 10 repetitions (reps) daily and to bilateral lower extremities 5-10 reps daily. When requested, no documentation related to provision of range of motion for R20 was provided. Nursing assistant (NA)-A was interviewed on 1/3/14 at 11:00 a.m. NA-A stated he was responsible for providing range of motion for R20, but had not done so because he did not have time to do so. R10 lacked range of motion services as recommended by the physical therapist On 1/3/14 at 2:15 p.m. R10 stated did not get range of motion. R10 was observed and asked to straighten hands. R10 was unable to straighten the 3rd and 4th fingers of the left hand related to contractures at mid joint. The care plan provided 1/3/14 indicated R10 had diagnoses of paraplegia, muscle weakness, pain	{F 318}	Facility DON and/or designee will be responsible for maintaining compliance. The facility alleges that it will be in substantial compliance with the standard indicated by 2/8/14.	

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{F 318}	Continued From page 17 in soft tissues of limb. Review of the nursing quarterly data collection tool dated 10/23/13 indicated no upper extremity functional impairment and impairment of both lower extremities. The collection tool stated no impairments of upper extremities but has limitation to bilateral lower extremities, no contractures. The collection tool indicated R10 received restorative nursing for range of motion. The quarterly MDS dated 10/24/13 indicated R10 required total assistance with transfer and extensive assistance with dressing and hygiene; functional limitations of both lower extremities; BIMS score of 14/15 (no mental impairment). The CAA dated 2/11/13 indicated physical limitations, weakness, limited range of motion, poor balance. The rational for care plan stated staff would work with resident to maintain/improve current function level of ADLs. The physical therapy evaluation of 7/31/13 indicated weakness, limited range of motion of ankle and R10 would benefit from range of motion program. The restorative nursing program flow sheet signed by physical therapy 8/6/13 directed active range of motion daily to both lower extremities 10 reps each. The care plan had an intervention dated 8/27/12 of active range of motion to lower extremities twice a day. When requested, no documentation related to provision of range of motion for R10 was provided. Nursing assistant NA-A was interviewed on 1/3/14 at 11:00 a.m. NA-A stated he was responsible for providing range of motion for R10, but had not done so because he did not have time to do so. The unit manager registered nurse (RN)-A was interviewed on 1/3/14 at 10:30 a.m. concerning	{F 318}		

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{F 318}	Continued From page 18 the range of motion for R4, R20, R10. RN-A indicated orders were developed by physical therapy for range of motion. RN-A stated range of motion was discussed in interdepartmental team (IDT) meetings, but was not sure about minutes being kept. RN-A stated that nursing was responsible to complete the MDS information related to range of motion and that nursing assistants complete the point of care (POC) computer information when range of motion was done. The director of nursing (DON) was interviewed on 1/3/14 at 10:50 a.m. about range of motion provided to R4, R20, R10. DON stated no IDT notes were maintained so there was no documented discussion of restorative nursing programs. She stated that POC documented by nursing assistants was not completed because of changes with the new facility ownership. DON stated that since no audits had been done, no one had noticed lack of documentation. DON added the nurse managers were responsible for documenting monthly related to range of motion participation and goals. During an interview on 1/3/14 at 4:00 p.m. the administrator indicated she was unable to find a policy/procedure related to resident range of motion, but thought that the sister facility would have one. Surveyor: Lee, Marietta R34 did not receive range of motion services as recommended by occupational therapy. Document review of the facility Admission Record	{F 318}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 318}	Continued From page 19 Resident Information form, identified R34 had diagnosis of Alzheimer's disease and paralysis agitans. The facility identified R34 on the quarterly Minimum Data Set (MDS) dated 10/10/13, to have short and long term memory problem, severely impaired decision making, total dependence on one to two staff for activities of daily living, received no restorative nursing program, no range of motion, no splints or brace assistance, and had functional limitation in range of motion impaired in upper extremity on one side. Document review of the facility quarterly range of motion/balance assessment dated 10/8/13, revealed R34 had functional limitation in range of motion on both sides of upper extremity, was non-ambulatory, transferred with mechanical lift and two staff, unable to follow commands and attempt to self-transfer or move extremities, and had impairment in both upper extremities. During interview on 1/3/14, at 10:39 a.m., nursing assistant-E (NA-E) stated hospice staff performed range of motion exercises to R34's hands when they visited. During observations on 1/3/14, at 10:50 a.m., R34 was positioned in geriatric chair in resident room with television on. R34 made no verbal response to questions. R34 was observed to have bilateral hands contracted with no splints on hands. During interview at that time, nursing assistant (NA)-G stated she performed range of motion exercises to R34's hands that morning. NA-G stated staff use to document range of motion exercises completed but the new	{F 318}		

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{F 318}	Continued From page 20 computer system in place on 12/20/13, did not allow for documentation of range of motion exercises. During observations on 1/3/14, at 11:30 a.m., NA-G pushed R34 in the geriatric chair to Oasis dining room. Observations at that time revealed R34's hands were contracted with no splints on hands. During interview at that time, NA-G verified R34's hands were contracted and stated R34 refused to have the hand splints applied that day. Document review of Occupational Therapy Recommendations to nursing staff dated 8/16/13, revealed instructions to wash bilateral hands, gentle range of motion, fit splints in right and left hands, wear two hours on in the morning and two hours in the afternoon. Document review of facility CAA worksheet dated 1/24/13, identified at #2-resident has potential for more independence with cueing, restorative nursing program, and/or task segmentation or other programs; #16-dated 1/22/13, identified delirium limits mobility, functional limitation in range of motion. Document review of facility visual/bedside kardex report with print date of 1/3/14, revealed R34's care instructions, although there were no instructions for range of motion. During interview on 1/3/14, at 10:50 a.m., director of nursing stated the facility lacked any documentation of range of motion performed, lacked interdisciplinary notes related to range of motion, lacked range of motion documentation by nursing assistants in point of care, due to a new	{F 318}		

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{F 318}	Continued From page 21 computer program, and no documentation of discussion of range of motion and restorative nursing programs. Director of nursing verified the facility had not completed any audits to determine if residents received range of motion. Director of nursing verified nurse managers were responsible for documenting a monthly note related to range of motion and participation in restorative nursing program. During interview on 1/3/14, at 11:50 a.m., executive director verified the facility new computer program was effective 12/20/13, and lacked documentation for range of motion exercises. During interview on 1/3/14, at 1:40 p.m., certified occupational therapy assistant (COTA) verified R34 was discharged from occupational therapy on 8/15/13, with goals met. COTA stated she had instructed nursing staff in range of motion hand exercises and splints. COTA stated facility procedure was for COTA to complete the occupational therapy recommendations to nursing staff form with therapy instructions for nursing to continue range of motion exercises. COTA stated she gave the recommendation form dated 8/16/13, to the clinical manager. COTA stated when resident discharged from occupational therapy, she was not aware if occupational therapy recommendations were followed by nursing. Document review of facility resident care plan report dated 8/26/13, identified focus of restorative nursing program to decrease risk of decreased mobility/contractures; goal to maintain range of motion and prevent any further contractures of hands; interventions included:	{F 318}		

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{F 318}	Continued From page 22 staff to wash bilateral hands, gentle range of motion to both hands, fit splints in right and left hands, allow finger room between straps and skin to prevent tightness, staff to apply two times a day for two hours. During interview on 1/3/14, at 1:45 p.m., executive director verified the facility lacked monthly clinical manager summary related to range of motion as written in facility plan of correction. Executive director verified the facility lacked evidence of range of motion exercises completed for R34, before or after the 12/20/13 new computer system.	{F 318}		
{F 323} SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: Lageson, Jennifer Based on observation, interview, and document review, the facility failed to consistently monitor, thoroughly investigate and report a left wrist injury in a timely manner for 1 of 3 residents (R67) reviewed and the facility failed to supervise residents in the dining room where a hot metal coffee pot and hanging electrical cords were located to ensure residents were safe from burns. This had the potential to affect 34 or 58 residents	{F 323}	**F323** Resident R67 skin was assessed by nursing re: the identified reddened area on the wrist. It is reasonable to conclude that the watch was the cause of the reddened area, the watch was removed and family notified. Plan of care was updated to include monitoring for skin conditions. The IDT reviewed recent resident incidents to determine compliance with facility policy and procedure.	2/8/14

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{F 323}	Continued From page 23 who had access to the coffee pot. Findings include: R67 had injury to the left wrist which included reddened swollen areas. However, the incident had not been thoroughly investigated, reported to the executive director per facility policy and monitored consistently. On 1/3/2014 at 10:30 a.m., R67's left wrist was observed. The resident had deep reddened marks almost all around the left wrist. The wrist was slightly swollen. The resident did not complain of pain. R 67 Was unable to tell the surveyor how it happened or what caused it. A quarterly Minimum Data Set dated 11/21/2013 was reviewed for R67. It identified the resident with moderate cognitive impairment and required extensive assist to total assist for activities of daily living. An Incident report dated 12/30/2013 was reviewed. It noted that during medication rounds that morning, a licensed practical nurse (LPN)-C noticed R67 had a reddened area on left wrist measuring 12 cm x 2 cm and above that another smaller reddened area measuring 6 cm x 1.5 cm. Area markings match that of R67's new watch. Resident was aware that wounds are from the watch. The immediate action was the watch was removed on 12/27/2013 by a nurse aide. The nurse aide had discovered R67's left arm and wrist to be swollen and having wound areas. LPN- C further documented the resident was identified as alert and confused with impaired memory. R67 owned the property and it was not reported as the cause was known.	{F 323}	Further follow-up and staff re-education will be done as needed. The DON or designee will do weekly audits of 3 incident reports to determine compliance with the facility's policy and procedure for reporting and investigating of resident incidents. Immediate re-education of staff will be completed if problems or inconsistencies are found. If there are continued issues with non-compliance, corrective action may be taken. The policy and procedure for VA reporting and investigating was reviewed by the IDT. The process for IDT review of incident reports was reviewed and updated. Staff education was done on the facility policy and procedure on VA reporting and investigation. Nurse Managers and nurses were re-trained on the correct way to	

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{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 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 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 board to be monitored.	{F 323}	input an incident report into PCC/Risk Management. The Director of Nursing, Administrator and Social Worker will monitor compliance with the facility's policy and procedures for incidents. The IDT team will review each incident report for completion. Metal Coffee pot, with electric cord attached, was removed immediately from dining room area and placed in the kitchen. Metal 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 created for when facility runs out of coffee in its Nescafe Coffee Machine. Policy was reviewed with all dietary staff. Education on environmental hazards was completed with all staff.	

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{F 323}	Continued From page 25 On 1/3/2014 at 10:55 a.m., LPN-C was interviewed regarding the incident of R67's left wrist. She said she became aware of it on 12/30/2013 (Monday) and made out the incident report at that time. The incident was found on 12/27/2013 by a nurse aide and a note was made by the nurse on that day (a Friday). LPN-C previewed the documentation of the previous nurse and indicated it was done on 12/28/2013 and identified a rash of the left wrist. LPN-C verified there was no further documentation of the incident or investigation. On 1/3/2014 at 11:05 a.m., DON was interviewed regarding reporting of the incident that occurred 12/27/2013 and was not taken care of until 12/30/2013. She indicated it has always been the policy to report immediately to the executive director (ED) and always was being done. On 1/3/2014 at 11:30 a.m., the DON indicated the wrist injury was discovered by a nurse on the 28th and she did not report according to the facility procedure. Another nurse noticed it on Monday and she reported it. It was reported to DON but not to ED, and the incident report was not completed on the 28th either. On 1/3/2014 at 1:44 p.m., the ED indicated the DON had informed her of the lack of documentation of a nurse regarding the incident for R67 on 12/27/2013? and incident report made out on 12/230/2013. The nurse didn't do the report, she verified she wasn't notified and the nurse was being counseled regarding that. On 1/3/2014 at 2:30 p.m., the DON indicated they should be monitoring the skin incident. It should be on the 24 hour board which then they are to	{F 323}	Random Environmental audits will be performed by the Maintenance Director or designee two times a month to monitor for compliance. Results of audits will be reported to the QA committee and action plans developed as needed. The facility will be substantial compliance with the standard indicated by 2/8/14.	

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{F 323}	Continued From page 26 document in the notes. They are to keep track until the nurse managers decide everything was okay. Surveyor: Sorensen, Gail R1 was sitting at a table in the dining room drinking coffee at 3:00 p.m. on 1/2/14. R1 stated she was able to get coffee herself and pointed us in the direction of a metal coffee pot on the counter in the dining room. On 1/2/14 at 3:00 p.m. a hot metal electric 100 cup coffee pot was observed plugged into the electrical outlet in the dining room. The pour spigot of the coffee pot rested over the counter edge. The electrical cord was wrapped around the front of the coffee pot and loosely under the front part of the counter to the electrical outlet on the back wall. There was no staff in dining room and staff did not have direct vision from the kitchen to see the coffee pot on the counter in the dining room. At 3:05 p.m. the dietary aid (DA)-C stated the coffee pot would come out anytime the Nescafe coffee machine was empty and the facility did not have dry coffee to make more. DA-C was unable to hold her hand against the pot for a count of 5 seconds due to it being hot to the touch. At 3:08 p.m. the administrator stated the facility had run out of coffee this morning and then they use the electric coffee pot for resident and visitor use. The administrator touched the coffee pot and said that it was to hot to touch for long. After touching the coffee pot the administrator removed the pot from resident access as it was to hot for residents to use safely. At 3:20 p.m. DA-C checked the temperature of the coffee when in the kitchen. The coffee in the	{F 323}		

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{F 323}	Continued From page 27 100 cup electrical coffee pot was 160 degrees. DA-A stated the facility did not run out of coffee very often, but that it had happened before and the metal coffee pot was used at that time. At 3:20 pm on 1/2/14 the certified dietary manager (CDM) was interviewed. CDM stated she had suggested the coffee pot be placed on the counter and that this 100 cup coffee pot was usually used when the facility ran out of coffee. She stated the coffee pot should have been placed in an area where residents did not have access for safety reasons. CDM stated she was unaware of any burns from the coffee. Review of incident reports from June through December 2013 did not reveal any resident burns from coffee. At 3:25 p.m. on 1/2/14, the director of nursing (DON) indicated there were 42 residents in the non-specialty unit in the nursing home that could have access to the coffee unless they were unable to get to the dining room themselves. At 4:00 p.m. DON provided a list of 34 residents that could independently have access to the coffee and at 5:15 p.m. stated none of these residents had advanced dementia. DON indicated R1 was on that list.	{F 323}		
{F 371} SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	{F 371}		

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{F 371}	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain a sanitary environment to prevent the spread of food borne illness which included food handling practices, equipment cleaning, and sanitizing, drying and storage of dishes for resident food use. This had the potential to affect 56 of 58 residents in the facility that had been provided food prepared and distributed from the facility kitchen. Findings include: Soiled gloves used to serve food: Food preparation/service was observed during the noon meal on 1/2/14 at 11:30 a.m. dietary aid (DA)-A was observed to put on gloves. DA-A then held a clip board and paper; scratched her leg; mixed juice; touched the rim of the drinking glasses as she placed them on the counter; opened the refrigerator door to get milk and poured the milk into one of the glass she had just set out; again opened the refrigerator door and touched items in the refrigerator; DA-A did not change her gloves. DA-A then opened the fluid thickener can, touch the bowl of a spoon, placed the spoon into the thickener and added the thickener to the milk. At 11:35 a.m. DA-A then wiped her hands on her apron. DA-A had not changed the gloves during the observation period of 11:30 a.m. until 11:35 a.m. while she was touching surfaces that would come in contact with resident food or after touching previously	{F 371}	**F 371** The facility will store, prepare, distribute and serve food under sanitary conditions. Staff was educated on infection control practices, the use of gloves, and the sanitary handling of equipment. The surface of the Dishwasher has been cleaned. The task of the cleaning the dishwasher was added to the cleaning checklist for each shift. Both fans were removed from service. All staff have been educated on the policy and procedure for testing the chemical balance for the the low temperature dishwashing machine and properly documenting the information. A monitoring system has been set up for assuring proper chemical levels are used and all cooks in-serviced.	2/8/14

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{F 371}	Continued From page 29 contaminated surfaces. During an interview on 1/2/14 at 11:36 a.m. DA-A stated that she had not changed her gloves and could not remember is she had received any training related to the use of gloves during new hire orientation but that she had worked in kitchens in the past. Dishwasher and sanitation of dishes: The dishwashing process was observed during the initial kitchen tour on 1/2/14 at 10:00 a.m. The dishwasher top above the clean dishes door was noted to have loose debris that would move when the door was opened to remove the dishes. At 12:05 p.m. on 1/2/14 the administrator and certified dietary manager (CDM) had also observed the debris on top of the dishwasher and indicated the area had not been cleaned. CDM stated that each time the dishwasher door was lifted some debris came out of the dishwasher and remained on the surface on top of the dishwasher and that she did not know the last time the dishwasher surface had been cleaned. Both the administrator and CDM stated that the debris could fall onto the clean dishes. At 10:50 a.m. on 1/2/14 during a tour with the dietary manager there were 2 fans (one attached to the wall and one free standing) observed blowing directly on the sanitized dishes after the dishes were removed from the dishwasher. CDM stated the fans were used to help dry the cleaned dishes. The dishwasher was a low temperature chemical sanitation dishwashing machine provided by ECO Labs. At 12:05 p.m. on 1/2/14 the facility dishwasher sanitation log for December 18	{F 371}	Staff have been educated on the expectations for equipment cleanliness and the task of maintaining the cleanliness, identifying concerns and initiating proper work orders as appropriate. On 1/2/14 the clear plastic bowl without a cleanable surface was removed from service. An Audit of all equipment was completed and items without a cleanable surface were removed from service and staff educated on the acceptable wear and tear of equipment. On 1/2/14 the pipes located in the range hood and the walls surrounding the range were cleaned and the task of maintaining the cleanliness of the hood, pipes and walls have been added to the daily cleaning checklist. Audits of infection control practices in the kitchen, kitchen cleanliness, equipment functioning, and compliance with	

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{F 371}	Continued From page 30 through 31 2013 was reviewed with the administrator and CDM. The chemical sanitation numbers documented on the facility log ranged from 40, 45, 89, 75 and 50 or 100 while the guidelines noted on the chemical test strips noted tests range of 10, 50, 100, and 200. CDM stated the facility documentation did not agree with the test strip range and should be documented at 50 or 100. CDM stated that ECO Lab had last been in the facility to test the dishwasher in November 2013 to verify the sanitation was at the correct level. CDM stated that if the sanitation was less than 40, staff were to let her know, but she had not been notified of a problem. CDM stated she would look at the logs and test the sanitation levels again, so felt the numbers were ok. Food preparation equipment: At 10:25 a.m. on 1/2/14, while touring the clean dish area with CDM, a clear plastic bowl was observed to have clear tape on the outside and an orange substance (looked like glue) on the inside to cover two large cracks in the bowl. CDM stated this was a clean dish and was used as part of the food puree processor. CDM stated that the bowl did not have a cleanable surface and placed the bowl to run through the dishwasher again. On 1/2/14 at 12:00 noon the Administrator and CDM observed the bowl of the Rotor puree processor on top of the processor ready for use. Administrator and CDM verified they were not sure what was used to glue the bowl crack and not sure if the bowl could be fully sanitized with the glued area in the bowl. At 12:30 p.m. the administrator stated the plastic bowl/cover would	{F 371}	documentation of chemical testing will be completed by dietary director or designee daily for one month and twice a week for a month. Results of the audits will be reduced based on compliance and recommendations from the QA committee. The Dietary Director is responsible for on-going compliance. The facility will be substantial compliance with the standard indicated by 2/8/14.	

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{F 371}	Continued From page 31 be removed from service until replaced. Dirty Hood located over the stove where food was prepared: The pipes contained within the hood were covered with dust particles. These pipes ran directly over the cook burners and the open griddle used for preparing resident food. The CDM stated the facility had contracted another service to come in November to clean the range hood, but that it had not been done since. CDM stated the dust could fall into uncovered pots during the cooking process. CDM stated dietary staff were to clean the walls and range hood whenever necessary. Review of the checklist entitled Dietary Cleaning Schedule for December 18,k 2013 through 12/29/13 were provided and reviewed. The checklist did not indicate staff cleaning the stove hood or painted walls during this time period.	{F 371}		

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	00758	A. BUILDING: _____ B. WING _____	R 01/03/2014

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{2 000}	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: An onsite follow-up visit was completed on 01/03/14. During this onsite visit it was determined that the following corrections orders/s # 0895, 1015, 1980 and 1985 were NOT corrected. This uncorrected order/s will remain in effect and will be reviewed at the next onsite visit. Also uncorrected order/s will be reviewed for	{2 000}	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.	

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{2 000}	Continued From page 1 possible penalty assessment/s.	{2 000}	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
{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: B. a resident with a limited range of motion receives appropriate treatment and services to	{2 895}		

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{2 895}	Continued From page 2 increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Uncorrected based on the following findings. The original licensing order issued on 11/08/13, will remain in effect. Penalty assessment issued. Based on observation, interview and record review, the facility failed to provide range of motion (ROM) services for 4 of 4 residents (R4, R20, R10, R34) reviewed for ROM services. Findings include: R4 lacked range of motion services as recommended by physical therapy and occupational therapy. R4 was observed on 1/3/14 at 11:50 a.m. sitting in a wheelchair in room. R4 was noted to have contractures at right elbow and wrist and also left wrist. R4 did not move upper extremities when requested. When asked if received range of 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	{2 895}		

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{2 895}	Continued From page 3 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 binder also had a picture guide labeled with R4's name with instructions for range of motion to lower extremities 5-10 repetitions daily and left upper extremities 10 repetitions daily signed by occupational therapy. When requested, no documentation related to provision of range of motion for R4 was provided. Nursing assistant NA-A was interviewed on 1/3/14 at 11:00 a.m. NA-A stated he was responsible for providing range of motion for R4, but had not done so because he did not have time to do so. R20 lacked range of motion services as recommended by the physical therapy and occupational therapy.	{2 895}		

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{2 895}	Continued From page 4 On 1/3/13 at 11:15 a.m. R20 was observed sitting in a wheelchair. When asked R10 was unable to straighten out both hands. R20 stated that staff did not do range of motion. The care plan provided 1/3/14 identified diagnoses of multiple sclerosis, dementia, pain in soft tissues of limbs, muscle weakness, abnormal posture, stiffness of 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. The physical therapy discharge summary dated 1/31/13 indicated a lower extremity range of motion program had been developed. The restorative nursing program form signed by occupation therapy directed upper extremity passive range of motion 10 repetitions daily. The care plan had interventions dated 2/28/13 that directed assist of one for passive range of motion to left upper extremity 10 repetitions (reps) daily and to bilateral lower extremities 5-10 reps daily.	{2 895}		

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{2 895}	Continued From page 5 When requested, no documentation related to provision of range of motion for R20 was provided. Nursing assistant (NA)-A was interviewed on 1/3/14 at 11:00 a.m. NA-A stated he was responsible for providing range of motion for R20, but had not done so because he did not have time to do so. R10 lacked range of motion services as recommended by the physical therapist On 1/3/14 at 2:15 p.m. R10 stated did not get range of motion. R10 was observed and asked to straighten hands. R10 was unable to straighten the 3rd and 4th fingers of the left hand related to contractures at mid joint. The care plan provided 1/3/14 indicated R10 had diagnoses of paraplegia, muscle weakness, pain in soft tissues of limb. Review of the nursing quarterly data collection tool dated 10/23/13 indicated no upper extremity functional impairment and impairment of both lower extremities. The collection tool stated no impairments of upper extremities but has limitation to bilateral lower extremities, no contractures. The collection tool indicated R10 received restorative nursing for range of motion. The quarterly MDS dated 10/24/13 indicated R10 required total assistance with transfer and extensive assistance with dressing and hygiene; functional limitations of both lower extremities; BIMS score of 14/15 (no mental impairment). The CAA dated 2/11/13 indicated physical limitations, weakness, limited range of motion, poor balance. The rational for care plan stated staff would work with resident to maintain/improve current function level of ADLs. The physical therapy evaluation of 7/31/13	{2 895}		

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{2 895}	Continued From page 6	{2 895}		

indicated weakness, limited range of motion of ankle and R10 would benefit from range of motion program.
The restorative nursing program flow sheet signed by physical therapy 8/6/13 directed active range of motion daily to both lower extremities 10 reps each. The care plan had an intervention dated 8/27/12 of active range of motion to lower extremities twice a day.
When requested, no documentation related to provision of range of motion for R10 was provided. Nursing assistant NA-A was interviewed on 1/3/14 at 11:00 a.m. NA-A stated he was responsible for providing range of motion for R10, but had not done so because he did not have time to do so.

The unit manager registered nurse (RN)-A was interviewed on 1/3/14 at 10:30 a.m. concerning the range of motion for R4, R20, R10. RN-A indicated orders were developed by physical therapy for range of motion. RN-A stated range of motion was discussed in interdepartmental team (IDT) meetings, but was not sure about minutes being kept. RN-A stated that nursing was responsible to complete the MDS information related to range of motion and that nursing assistants complete the point of care (POC) computer information when range of motion was done.
The director of nursing (DON) was interviewed on 1/3/14 at 10:50 a.m. about range of motion provided to R4, R20, R10. DON stated no IDT notes were maintained so there was no documented discussion of restorative nursing programs. She stated that POC documented by nursing assistants was not completed because of changes with the new facility ownership. DON stated that since no audits had been done, no one had noticed lack of documentation. DON

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{2 895}	Continued From page 7 added the nurse managers were responsible for documenting monthly related to range of motion participation and goals. During an interview on 1/3/14 at 4:00 p.m. the administrator indicated she was unable to find a policy/procedure related to resident range of motion, but thought that the sister facility would have one. R34 did not receive range of motion services as recommended by occupational therapy. Document review of the facility Admission Record Resident Information form, identified R34 had diagnosis of Alzheimer's disease and paralysis agitans. The facility identified R34 on the quarterly Minimum Data Set (MDS) dated 10/10/13, to have short and long term memory problem, severely impaired decision making, total dependence on one to two staff for activities of daily living, received no restorative nursing program, no range of motion, no splints or brace assistance, and had functional limitation in range of motion impaired in upper extremity on one side. Document review of the facility quarterly range of motion/balance assessment dated 10/8/13, revealed R34 had functional limitation in range of motion on both sides of upper extremity, was non-ambulatory, transferred with mechanical lift and two staff, unable to follow commands and attempt to self-transfer or move extremities, and had impairment in both upper extremities. During interview on 1/3/14, at 10:39 a.m., nursing assistant-E (NA-E) stated hospice staff performed	{2 895}		

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{2 895}	Continued From page 8 range of motion exercises to R34's hands when they visited. During observations on 1/3/14, at 10:50 a.m., R34 was positioned in geriatric chair in resident room with television on. R34 made no verbal response to questions. R34 was observed to have bilateral hands contracted with no splints on hands. During interview at that time, nursing assistant (NA)-G stated she performed range of motion exercises to R34's hands that morning. NA-G stated staff use to document range of motion exercises completed but the new computer system in place on 12/20/13, did not allow for documentation of range of motion exercises. During observations on 1/3/14, at 11:30 a.m., NA-G pushed R34 in the geriatric chair to Oasis dining room. Observations at that time revealed R34's hands were contracted with no splints on hands. During interview at that time, NA-G verified R34's hands were contracted and stated R34 refused to have the hand splints applied that day. Document review of Occupational Therapy Recommendations to nursing staff dated 8/16/13, revealed instructions to wash bilateral hands, gentle range of motion, fit splints in right and left hands, wear two hours on in the morning and two hours in the afternoon. Document review of facility CAA worksheet dated 1/24/13, identified at #2-resident has potential for more independence with cueing, restorative nursing program, and/or task segmentation or other programs; #16-dated 1/22/13, identified delirium limits mobility, functional limitation in range of motion.	{2 895}		

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{2 895}	Continued From page 9 Document review of facility visual/bedside kardex report with print date of 1/3/14, revealed R34's care instructions, although there were no instructions for range of motion. During interview on 1/3/14, at 10:50 a.m., director of nursing stated the facility lacked any documentation of range of motion performed, lacked interdisciplinary notes related to range of motion, lacked range of motion documentation by nursing assistants in point of care, due to a new computer program, and no documentation of discussion of range of motion and restorative nursing programs. Director of nursing verified the facility had not completed any audits to determine if residents received range of motion. Director of nursing verified nurse managers were responsible for documenting a monthly note related to range of motion and participation in restorative nursing program. During interview on 1/3/14, at 11:50 a.m., executive director verified the facility new computer program was effective 12/20/13, and lacked documentation for range of motion exercises. During interview on 1/3/14, at 1:40 p.m., certified occupational therapy assistant (COTA) verified R34 was discharged from occupational therapy on 8/15/13, with goals met. COTA stated she had instructed nursing staff in range of motion hand exercises and splints. COTA stated facility procedure was for COTA to complete the occupational therapy recommendations to nursing staff form with therapy instructions for nursing to continue range of motion exercises. COTA stated she gave the recommendation form dated 8/16/13, to the clinical manager. COTA	{2 895}		

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{2 895}	Continued From page 10 stated when resident discharged from occupational therapy, she was not aware if occupational therapy recommendations were followed by nursing. Document review of facility resident care plan report dated 8/26/13, identified focus of restorative nursing program to decrease risk of decreased mobility/contractures; goal to maintain range of motion and prevent any further contractures of hands; interventions included: staff to wash bilateral hands, gentle range of motion to both hands, fit splints in right and left hands, allow finger room between straps and skin to prevent tightness, staff to apply two times a day for two hours. During interview on 1/3/14, at 1:45 p.m., executive director verified the facility lacked monthly clinical manager summary related to range of motion as written in facility plan of correction. Executive director verified the facility lacked evidence of range of motion exercises completed for R34, before or after the 12/20/13 new computer system.	{2 895}		
{21015}	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Uncorrected based on the following findings. The original licensing order issued on 11/08/13, will	{21015}		

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{21015}	Continued From page 11 remain in effect. Penalty assessment issued. Based on observation, interview, and document review, the facility failed to maintain a sanitary environment to prevent the spread of food borne illness which included food handling practices, equipment cleaning, and sanitizing, drying and storage of dishes for resident food use. This had the potential to affect 56 of 58 residents in the facility that had been provided food prepared and distributed from the facility kitchen. Findings include: Soiled gloves used to serve food: Food preparation/service was observed during the noon meal on 1/2/14 at 11:30 a.m. dietary aid (DA)-A was observed to put on gloves. DA-A then held a clip board and paper; scratched her leg; mixed juice; touched the rim of the drinking glasses as she placed them on the counter; opened the refrigerator door to get milk and poured the milk into one of the glass she had just set out; again opened the refrigerator door and touched items in the refrigerator; DA-A did not change her gloves. DA-A then opened the fluid thickener can, touch the bowl of a spoon, placed the spoon into the thickener and added the thickener to the milk. At 11:35 a.m. DA-A then wiped her hands on her apron. DA-A had not changed the gloves during the observation period of 11:30 a.m. until 11:35 a.m. while she was touching surfaces that would come in contact with resident food or after touching previously contaminated surfaces. During an interview on 1/2/14 at 11:36 a.m. DA-A stated that she had not changed her gloves and could not remember is she had received any training related to the use of gloves during new hire orientation but that she had worked in kitchens in the past.	{21015}		

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{21015}	Continued From page 12 Dishwasher and sanitation of dishes: The dishwashing process was observed during the initial kitchen tour on 1/2/14 at 10:00 a.m. The dishwasher top above the clean dishes door was noted to have loose debris that would move when the door was opened to remove the dishes. At 12:05 p.m. on 1/2/14 the administrator and certified dietary manager (CDM) had also observed the debris on top of the dishwasher and indicated the area had not been cleaned. CDM stated that each time the dishwasher door was lifted some debris came out of the dishwasher and remained on the surface on top of the dishwasher and that she did not know the last time the dishwasher surface had been cleaned. Both the administrator and CDM stated that the debris could fall onto the clean dishes. At 10:50 a.m. on 1/2/14 during a tour with the dietary manager there were 2 fans (one attached to the wall and one free standing) observed blowing directly on the sanitized dishes after the dishes were removed from the dishwasher. CDM stated the fans were used to help dry the cleaned dishes. The dishwasher was a low temperature chemical sanitation dishwashing machine provided by ECO Labs. At 12:05 p.m. on 1/2/14 the facility dishwasher sanitation log for December 18 through 31 2013 was reviewed with the administrator and CDM. The chemical sanitation numbers documented on the facility log ranged from 40, 45, 89, 75 and 50 or 100 while the guidelines noted on the chemical test strips noted tests range of 10, 50, 100, and 200. CDM stated the facility documentation did not agree with the test strip range and should be documented at 50 or 100. CDM stated that ECO	{21015}		

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	00758	A. BUILDING: _____ B. WING _____	R 01/03/2014

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{21015}	Continued From page 13 Lab had last been in the facility to test the dishwasher in November 2013 to verify the sanitation was at the correct level. CDM stated that if the sanitation was less than 40, staff were to let her know, but she had not been notified of a problem. CDM stated she would look at the logs and test the sanitation levels again, so felt the numbers were ok. Food preparation equipment: At 10:25 a.m. on 1/2/14, while touring the clean dish area with CDM, a clear plastic bowl was observed to have clear tape on the outside and an orange substance (looked like glue) on the inside to cover two large cracks in the bowl. CDM stated this was a clean dish and was used as part of the food puree processor. CDM stated that the bowl did not have a cleanable surface and placed the bowl to run through the dishwasher again. On 1/2/14 at 12:00 noon the Administrator and CDM observed the bowl of the Rotor puree processor on top of the processor ready for use. Administrator and CDM verified they were not sure what was used to glue the bowl crack and not sure if the bowl could be fully sanitized with the glued area in the bowl. At 12:30 p.m. the administrator stated the plastic bowl/cover would be removed from service until replaced. Dirty Hood located over the stove where food was prepared: The pipes contained within the hood were covered with dust particles. These pipes ran directly over the cook burners and the open griddle used for preparing resident food. The CDM stated the facility had contracted another service to come in November to clean the range	{21015}		

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{21015}	Continued From page 14 hood, but that it had not been done since. CDM stated the dust could fall into uncovered pots during the cooking process. CDM stated dietary staff were to clean the walls and range hood whenever necessary. Review of the checklist entitled Dietary Cleaning Schedule for December 18, 2013 through 12/29/13 were provided and reviewed. The checklist did not indicate staff cleaning the stove hood or painted walls during this time period.	{21015}		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of	21980		

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21980	Continued From page 15 known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to immediately report allegations of verbal abuse to the executive director/administrator nor to the designated state agency immediately nor complete a thurough investigation and implement interventions to prevent further inicdenets from reoccuring and protect the resident while the investigation was conducted for 1 of 1 resident (R6) who was reviewed for allegations of abuse. This had the potential to affect all 58 residents in the facility. Findings include:	21980		

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21980	Continued From page 16 R6 received continued verbal mistreatment without thorough investigation and interventions in place to prevent further verbal mistreatment by family member. During observations on 1/3/14, at 2:10 p.m., surveyor heard family (F)-A of R6 ' s in the lobby loudly state, " Jesus woman shut up " to R6. Observations at that time revealed R6 sat in a wheelchair in the lobby and three staff members were also located in the lobby. Surveyor immediately reported the incident to the nurse coordinator who was in charge of the residents on 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. R6 was identified on the facility Admission Record Resident Information form dated 8/26/10, to have diagnosis that included diabetes mellitus and congestive heart failure. R6 was identified by the facility on the quarterly Minimum Data Set (MDS); an assessment dated 10/23/13, to have intact cognition, required extensive assistance of one staff for activities of daily living, and had lower extremity range of motion functional limitation on both sides. During interview on 1/3/14, at 2:25 p.m., the	21980		

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21980	Continued From page 17	21980		

executive director and SW verified they were aware of F-A ' s verbal behavior toward R6. Although executive director and SW stated they had talked with R6 and F-A in the past, they verified the facility lacked evidence of a thorough investigation of the behaviors and also verified they had not reported the verbal behaviors to the designated state agency before determining it had not been considered verbal abuse.

During interview on 1/3/14, at 3:00 p.m., executive director stated she expected staff to report incidents of alleged verbal abuse to her and to complete an incident report. Executive director verified there have been no incidents reported to her of verbal abuse in the facility and no incident reports of verbal abuse involving R6 and F-A.

During interview on 1/3/14, at 3:05 p.m., R6 stated she was not "concerned" about verbal mistreatment, but that she would be " more concerned about physical abuse." R6 stated F-A had not hit her. R6 stated she had lived at the facility for six years and F-A visited her every day. R6 stated F-A yelled at her a lot but that she lets it "go in one ear and out the other." R6 stated verbal abuse did not "scare " her but that "doesn't scare her but physical abuse" did scare her. R6 stated F-A often "angers a lot." R6 stated although she had not done so, if F-A was "verbal" with her, she would tell family member to go home and she would report to the nurses to watch for the return of F-A. R6 stated she felt safe in the facility.

Facility staff interviews included the following:

During interview on 1/3/14, at 2:55 p.m., receptionist-A (R-A) stated she was aware of F-A

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21980	Continued From page 18 ' s behavior. R-A stated most of the time F-A spoke to R6 in a " disrespectful " tone, also F-A yells at R6 "You never listen to me." R-A stated she usually reported this behavior to social worker or registered nurse manager or executive director, so " someone can deal with it." R-A stated she would call vulnerable adult number if there were no supervisor to notify. R-A stated social services or director of nursing had not given any recommendations to R-A for what to do when F-A treats R6 disrespectfully except to report the incident to nurse, director of nursing or executive director. During interview on 1/3/14, at 3:05 p.m., housekeeper-A (HSK-A) stated they had been aware of F-A ' s behavior of loud, rude and nasty behavior towards R6. HSK-A stated the behavior had occurred for the past 2 to 3 weeks and that HSK-A did not get involved. HSK-A stated sometimes R6 talked back to F-A during F-A yelling. During interview on 1/3/14, at 3:08 p.m., registered nurse (RN)-C stated F-A, alleged verbal behavior was just their personality and that sometimes R6 would talk back to family member. RN-C stated if she did hear something she felt was abusive from F-A towards R6, RN-C would report to facility social worker or the evening supervisor, since the family member visited in the evenings. Document review of facility incident report forms from 12/18/13 to 1/2/14, revealed no reports of alleged verbal abuse towards R6. Document review of R6 progress notes dated 10/3/13 to 1/1/14, revealed no evidence of incidents of verbal mistreatment by family	21980		

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21980	Continued From page 19 member. Document review of R6 care plan dated 11/20/13, revealed focus resident was vulnerable to abuse by staff and/or other residents related to impaired physical mobility. Care plan goal was safety would be protected through staff intervention. Interventions included to encourage resident to report to staff if resident felt threatened or bothered by other residents and/or staff. R6 care plan lacked interventions for continued verbal behaviors by family member. Document review of facility Resident Incident Process policy revised dated 7/13, revealed the following: Procedure: 1. Immediately upon witnessing or being notified of an accident, incident or altercation involving a resident, an investigation of the facts surrounding the incident is initiated. Any fall, injury of unknown or known origin, (including bruises and skin tears) medication errors, allegation of injury, allegation of abuse, neglect and/or maltreatment, self-abuse/suicide attempt, suspicious death of a resident, elopement (this includes allegations of resident to resident abuse and incidents of alleged financial exploitation) will be documented in the Risk Management Program of the EMR. 3. Follow all immediate reporting and notification procedures for mandated reporting and elder justice act for situations of alleged abuse/neglect, including immediate notification to the Executive Director. 5. The Executive Director, Director of Nursing and /or Social Service Director and IDT Designees ensures that appropriate follow-up, notifications, and investigation is completed with the incident, and documents the follow-up.	21980		

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21980	Continued From page 20 6. Staff are to implement interventions for safety to prevent reoccurrence. Document review of facility Resident/client/participant Protection Policy and Procedure revised dated 12/12, directed staff the following: page 5: #2. Investigation: a. Upon receiving a complaint of alleged maltreatment, the ED (executive director), Director of Nursing/designee and Social services or designee will coordinate an investigation, which will include completion of witness statements. b. All parties involved including two of the following-staff, resident/client/participants or visitors, who were potentially involved, or observed the alleged incident are to be interviewed by ED, DON, Social services or designee. Statements should be written on the Witness Interview Form. Interviews should be conducted with 2 staff members present whenever possible/appropriate. f. Identify and implement appropriate interventions, i.e., increased 1:1, psychological consultation. h. The investigation and written findings are completed and reviewed with the Executive Director/or designated representative, and to other officials in accordance with state law. A plan for further action is determined with input from appropriate personnel. Completion of the Investigative Data Sheet will ensue to prevent further occurrences as specified per policy. k. The facility/service will investigate all alleged violations and will prevent further potential abuse while the investigation is in progress.	21980		

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21980	Continued From page 21 Page 6: #4. Reporting Maltreatment of Individuals: a. Who must report suspected maltreatment of a resident/client/participant? Any employee, 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 within their hearing distance, regardless of their age, ability to comprehend, or disability.	21980		

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21980	Continued From page 22 Page 13: D. Psychological/Emotional Abuse: #6. Use of repeated or malicious oral, written or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening. 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 F-A had moved into the area. Executive director stated she was not aware of any incidents of F-A exhibiting verbal behaviors toward other residents. She stated F-A had "sworn" at staff one time that she was aware of and executive director immediately talked to F-A concerning this behavior. Executive director verified there was no documentation of this conversation with F-A. Executive director stated she talked with the "Ombudsman" one time "either the last week of November 2013 or first week of December 2013" in regards to F-A and R6 ' s situation. Executive director verified there was no documentation of this conversation either. Executive director stated the facility had no incident reports related to F-A ' s alleged verbal behaviors. Executive director stated the facility had not reported R6's alleged verbal abuse by F-A to the office of health facility (OHFC) as this behavior had been ongoing. Executive director verified the facility lacked a thorough investigation of the ongoing allegation of verbal abuse by F-A in regards to R6. Executive director than said that any allegation of abuse of any type is to be reported to her immediately. TIME PERIOD FOR CORRECTION: twenty-one (21) days.	21980		

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21985	MN St. Statute 626.557 Subd. 3a Reporting - Maltreatment of Vulnerable Adults Subd. 3a. Report not required. The following events are not required to be reported under this section: (a) A circumstance where federal law specifically prohibits a person from disclosing patient identifying information in connection with a report of suspected maltreatment, unless the vulnerable adult, or the vulnerable adult's guardian, conservator, or legal representative, has consented to disclosure in a manner which conforms to federal requirements. Facilities whose patients or residents are covered by such a federal law shall seek consent to the disclosure of suspected maltreatment from each patient or resident, or a guardian, conservator, or legal representative, upon the patient's or resident's admission to the facility. Persons who are prohibited by federal law from reporting an incident of suspected maltreatment shall immediately seek consent to make a report. (b) Verbal or physical aggression occurring between patients, residents, or clients of a facility, or self-abusive behavior by these persons does not constitute abuse unless the behavior causes serious harm. The operator of the facility or a designee shall record incidents of aggression and self-abusive behavior to facilitate review by licensing agencies and county and local welfare agencies. (c) Accidents as defined in section 626.5572, subdivision 3. (d) Events occurring in a facility that result from an individual's error in the provision of therapeutic	21985		

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21985	Continued From page 24 conduct to a vulnerable adult, as provided in section 626.5572, subdivision 17, paragraph (c), clause (4). (e) Nothing in this section shall be construed to require a report of financial exploitation, as defined in section 626.5572, subdivision 9, solely on the basis of the transfer of money or property by gift or as compensation for services rendered. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement their Resident Incident Process and Resident/client/participant Protection Policy and Procedure which indicated allegations of abuse were to be immediately reported to the executive director, reported to the designated state agency, failed to initiate an investigation, and failed to implement interventions to protect 1 of 1 resident (R6) observed for verbal maltreatment. This had the potential to affect all 58 residents residing in the facility who were vulnerable to abuse due to staff failure to implement their policies. Findings include: R6 experienced on-going verbal mistreatment from a family (F)-A member for approximately eleven weeks without immediate executive director notification, without designated state agency notification, without thorough investigation, and without interventions in place to protect R6 from ongoing verbal mistreatment, according to facility vulnerable adult policies. Document review of facility Resident Incident Process policy revised dated 7/13, revealed the	21985		

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21985	Continued From page 25 following: Procedure: 1. Immediately upon witnessing or being notified of an accident, incident or altercation involving a resident, an investigation of the facts surrounding the incident is initiated. Any fall, injury of unknown or known origin, (including bruises and skin tears) medication errors, allegation of injury, allegation of abuse, neglect and/or maltreatment, self abuse/suicide attempt, suspicious death of a resident, elopement (this includes allegations of resident to resident abuse and incidents of alleged financial exploitation) will be documented in the Risk Management Program of the EMR. 3. Follow all immediate reporting and notification procedures for mandated reporting and elder justice act for situations of alleged abuse/neglect, including immediate notification to the Executive Director. 5. The Executive Director, Director of Nursing and /or Social Service Director and IDT Designees ensures that appropriate follow-up, notifications, and investigation is completed with the incident, and documents the follow-up. 6. Staff are to implement interventions for safety to prevent reoccurrence. Document review of facility Resident/client/participant Protection Policy and Procedure revised dated 12/12, directed staff the following: page 5: #2. Investigation: a. Upon receiving a complaint of alleged maltreatment, the ED (executive director), Director of Nursing/designee and Social services or designee will coordinate an investigation, which will include completion of witness statements. b. All parties involved including two of the	21985		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00758	A. BUILDING: _____ B. WING _____	R 01/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS CARE CENTER	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21985	Continued From page 26 following-staff, resident/client/participants or visitors, who were potentially involved, or observed the alleged incident are to be interviewed by ED, DON, Social services or designee. Statements should be written on the Witness Interview Form. Interviews should be conducted with 2 staff members present whenever possible/appropriate. f. Identify and implement appropriate interventions, i.e., increased 1:1, psychological consultation. h. The investigation and written findings are completed and reviewed with the Executive Director/or designated representative, and to other officials in accordance with state law. A plan for further action is determined with input from appropriate personnel. Completion of the Investigative Data Sheet will ensue to prevent further occurrences as specified per policy. k. The facility/service will investigate all alleged violations and will prevent further potential abuse while the investigation is in progress. Page 6: #4. Reporting Maltreatment of Individuals: a. Who must report suspected maltreatment of a resident/client/participant? Any employee, 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	21985		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00758	A. BUILDING: _____ B. WING _____	R 01/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS CARE CENTER	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21985	Continued From page 27	21985		

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, written or gestured language toward a
vulnerable adult or the treatment of a vulnerable adult which would be considered
by a reasonable person to be disparaging, derogatory, humiliating, harassing, or
threatening.

During interview on 1/3/14, at 3:12 p.m., registered nurse-B (RN-B) stated was aware of R6 ' s family member ' s behavior. RN-B verified the family member talked loud, rude and nasty to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00758	A. BUILDING: _____ B. WING _____	R 01/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS CARE CENTER	**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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21985	Continued From page 28 other residents. RN-B stated the behavior had 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. TIME PERIOD FOR CORRECTION: twenty-one (21) days.	21985		

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

F5304023

2000 CODE

Form Approved
OMB Exempt

FIRE SAFETY SURVEY REPORT 2000 CODE - HEALTH CARE
Medicare – Medicaid

1. (A) PROVIDER NUMBER	1. (B) MEDICAID I.D. NO.
K1 245304	K2

PART I — Life Safety Code, New and Existing
PART IV — Waiver Recommendation Form

Identifying information as shown in applicable records. Enter changes, if any, alongside each item, giving date of change.

2. NAME OF FACILITY	2. (A) MULTIPLE CONSTRUCTION (BLDGS)	2. (B) ADDRESS OF FACILITY (STREET, CITY, STATE, ZIP CODE)	
ANGELS CARE CENTER	A. BUILDING 01 B. WING C. FLOOR K3	300 NORTH DOW STREET CANNON FALLS, MN 55009	A. (•) Fully Sprinklered (All required areas are sprinklered) B. ( ) Partially Sprinklered (Not all required areas are sprinklered) C. ( ) None (No sprinkler system) K0180

3. SURVEY FOR	4. DATE OF SURVEY	DATE OF PLAN APPROVAL	SURVEY UNDER
[✓] MEDICARE [✓] MEDICAID	K4 11/05/2013	K6	5. [✓] 2000 EXISTING 6. [ ] 2000 NEW K7

5. SURVEY FOR CERTIFICATION OF

1. ( ) HOSPITAL 2. (•) SKILLED/NURSING FACILITY 4. ( ) ICF/MR UNDER HEALTH CARE 5. ( ) HOSPICE

IF "2" OR "5" ABOVE IS MARKED, CHECK APPROPRIATE ITEM(S) BELOW

1. (•) ENTIRE FACILITY 2. ( ) DISTINCT PART OF (SPECIFY) _____

3. [ ] IF DISTINCT PART OF HOSPITAL, IS HOSPITAL ACCREDITED?
a. ( ) YES b. (•) NO

6. BED COMPOSITION				
a. TOTAL NO. OF BEDS IN THE FACILITY 89	b. NUMBER OF HOSPITAL BEDS CERTIFIED FOR MEDICARE 0	c. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICARE 89	d. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICAID 89	e. NUMBER OF NF or ICF/MR BEDS CERTIFIED FOR MEDICAID 0

7. A. ( ) THE FACILITY MEETS, BASED UPON (CHECK ALL APPROPRIATE BOXES)

1. [ ] COMPLIANCE WITH ALL PROVISIONS 2. (•) ACCEPTANCE OF A PLAN OF CORRECTION 3. ( ) RECOMMENDED WAIVERS 4. ( ) FSES 5. ( ) PERFORMANCE BASED DESIGN

B. (•) THE FACILITY DOES NOT MEET THE STANDARD
K9

SURVEYOR (Signature)	TITLE	OFFICE	DATE
SURVEYOR ID 25822 K10	Deputy State Fire Marshal	State Fire Marshal	11/052013
FIRE AUTHORITY OFFICIAL (Signature)	TITLE	OFFICE	DATE
	Fire Safety Supervisor	State Fire Marshal	11-19-13

ID PREFIX		MET	NOT MET	N/A	REMARKS
	PART I - LSC REQUIREMENTS - Items in italics relate to the FSES **BUILDING CONSTRUCTION**				K11 - 2 hour building separation between Nursing home 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	◉	○	○	
K12	2000 EXISTING 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	◉	○	○	K12 - 1977 - Original 1-story - no basement 1982 - Addition 1-story - no basement 1985 - Addition 1-story - no basement
	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) — Not over two stories with complete automatic sprinkler system.				
	5 ○ V (111)				
	6 ○ IV (2HH)				
	7 ○ II (000)				
	8 ○ III (200) — Not over one story with complete automatic sprinkler system.				
	9 ○ V (000)				
	☐ 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.*				

ID PREFIX					MET	NOT MET	N/A	REMARKS
K12	2000 NEW Building construction type and height meets one of the following: 18.1.6.2, 18.1.6.3, 18.3.5.1.							
	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)	Not over one story with complete automatic sprinkler system.				
	4		V (111)					
	5		IV (2HH)					
	6		II (000)					
	7		III (200)	Not Permitted				
	8		V (000)					
	☐ 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 PREFIX		MET	NOT MET	N/A	REMARKS
	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 1/28 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* B	○	○		
	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* B	○	○		
	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
K16	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	2000 EXISTING 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* smk rest *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	○	○		
	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		MET	NOT MET	N/A	REMARKS
	VERTICAL OPENINGS				K21 - Magnetic Door hold opens, that have full corridor smoke detection, that is interconnected with the building fire alarm system.
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.	○	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	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	○	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K27	2000 EXISTING Doors in smoke barriers have at least a 20 minute fire protection rating or are at least 1¾ inch thick solid bonded core wood. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors shall be self-closing or automatic-closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7	○	○	○	
	2000 NEW Doors in smoke barriers have at least a 20 minute fire protection rating or are at least 1¾ inch thick solid bonded core wood. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Swinging doors shall be arranged so that each door swings in an opposite direction. Doors shall be self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8				
K28	2000 EXISTING Door openings in smoke barriers shall provide a minimum clear width of 32 inches (81 cm) for swinging or horizontal doors. 19.3.7.7	○	○	○	
	2000 NEW Door openings in smoke barriers are installed as swinging or horizontal doors shall provide a minimum clear width as follows: 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				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K104	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				
K29	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	Automatic Sprinkler	Separation	N/A
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	✔	✔	

Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.

ID PREFIX		MET	NOT MET	N/A	REMARKS
	2000 NEW Hazardous areas are protected in accordance with 8.4. The areas shall be enclosed with a one hour fire-rated barrier, with a ¾ hour fire-rated door, without windows (in accordance with 8.4). Doors shall be self-closing or automatic closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, 18.3.5.1.				

Area	Automatic Sprinkler	Separation	N/A
a. Boiler and Fuel-Fired Heater Rooms			
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 hazardous areas that are deficient in REMARKS.

K30	Gift shops shall be protected as hazardous areas when used for storage or display of combustibles in quantities considered hazardous. Non-rated walls may separate gift shops that are not considered hazardous, have separate protected storage and that are completely sprinkled. Gift shops may be open to the corridor if they are not considered hazardous, have separate protected storage, are completely sprinklered and do not exceed 500 square feet. 18.3.2.5, 19.3.2.5	○	○	○	

Area	Automatic Sprinkler	Separation	N/A
L. Gift Shop storing hazardous quantities of combustibles	☐	☐	☑

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.				

ID PREFIX		MET	NOT MET	N/A	REMARKS
	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	○	○		

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.)	○	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
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				
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 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	○	○	○	

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				K54 - The facility has full corridor smoke detection, with smoke detection in areas open to the corridor, that are interconnected to building fire alarm system, that has automatic notification to the fire department.
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 ☐ Bath	○	○	◉	
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 PREFIX		MET	NOT MET	N/A	REMARKS
	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				
K60	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				
K56	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.				
K154	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. 10/11/2013				

ID PREFIX		MET	NOT MET	N/A	REMARKS
	B. Show who provided the service. Gerry				
	C. Note the source of water supply for the automatic sprinkler system. City Water				
	(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 international 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 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.	○	○	○	K67 - Documentation review of the fire damper testing log for the past 4 years revealed, all of the fire/smoke dampers have not been tested with-in the last 4 years. Last documented test was on 9/9/2009.
	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 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	○	○	●	

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 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	○	○	○	
K74	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.	○	○	○	
K75	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/ft^2 (20.4 L/m^2). A	○	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	capacity of 32 gal (121 L) shall not be exceeded within any 64-ft^2 (5.9-m^2) 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	○	○	○	
	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 PREFIX		MET	NOT MET	N/A	REMARKS
	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)	○	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K142	All occupancies containing hyperbaric facilities shall comply with NFPA 99, Standard for Health Care Facilities, Chapter 19.	○	○	○	
K143	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				
K106	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)	○	○	○	
K107	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			☑	
K144	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)	○	○	○	
K145	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 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	Office	Date
Fire Authority Official *(Signature)*	Title	Office	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 CONSTRUCTION

TOTAL NUMBER OF BUILDINGS _____

NUMBER OF THIS BUILDING _____

☐

A BUILDING
B WING
C FLOOR
D APARTMENT UNIT

LSC FORM INDICATOR

Health Care Form		
12	2786R	2000 EXISTING
13	2786R	2000 NEW

ASC Form		
14	2786U	2000 EXISTING
15	2786U	2000 NEW

ICF/MR Form		
16	2786V, W, X	2000 EXISTING
17	2786V, W, X	2000 NEW

* K7 ☐ SELECT NUMBER OF FORM USED FROM ABOVE

COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21

SMALL (16 BEDS OR LESS)

K8: ☐ 1 PROMPT 2 SLOW 3 IMPRACTICAL

LARGE

K8: ☐ 4 PROMPT 5 SLOW 6 IMPRACTICAL

APARTMENT HOUSE

K8: ☐ 7 PROMPT 8 SLOW 9 IMPRACTICAL

(Check if K29 or K56 are marked as not applicable in the 2786 M, R, T, U, V, W, X and Y.)

K29: ☐ K56: ☐

ENTER E – SCORE HERE

K5: ☐ e.g. 2.5

*K9: FACILITY MEETS LSC BASED ON *(Check all that apply)*

A1. ☐ (COMP. WITH ALL PROVISIONS)

A2. ☐ (ACCEPTABLE POC)

A3. ☐ (WAIVERS)

A4. ☐ (FSES)

A5. ☐ (PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC

B. ☐

K0180

A. ☐ FULLY SPRINKLERED (All required areas are sprinklered)

B. ☐ PARTIALLY SPRINKLERED (Not all required areas are sprinklered)

C. ☐ NONE (No sprinkler system)

* MANDATORY

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

F5304023

2000 CODE

Form Approved
OMB Exempt

FIRE SAFETY SURVEY REPORT 2000 CODE - HEALTH CARE
Medicare – Medicaid

1. (A) PROVIDER NUMBER	1. (B) MEDICAID I.D. NO.
K1 245304	K2

PART I — Life Safety Code, New and Existing
PART IV — Waiver Recommendation Form

Identifying information as shown in applicable records. Enter changes, if any, alongside each item, giving date of change.

2. NAME OF FACILITY	2. (A) MULTIPLE CONSTRUCTION (BLDGS)	2. (B) ADDRESS OF FACILITY (STREET, CITY, STATE, ZIP CODE)	
ANGELS CARE CENTER	A. BUILDING 02 B. WING C. FLOOR K3	300 NORTH DOW STREET CANNON FALLS, MN 55009	A. (●) Fully Sprinklered (All required areas are sprinklered) B. ( ) Partially Sprinklered (Not all required areas are sprinklered) C. ( ) None (No sprinkler system) K0180

3. SURVEY FOR	4. DATE OF SURVEY	DATE OF PLAN APPROVAL	SURVEY UNDER
[✓] MEDICARE [✓] MEDICAID	K4 11/05/2013	K6	5. [ ] 2000 EXISTING 6. [✓] 2000 NEW K7

5. SURVEY FOR CERTIFICATION OF

1. ( ) HOSPITAL 2. (●) SKILLED/NURSING FACILITY 4. ( ) ICF/MR UNDER HEALTH CARE 5. ( ) HOSPICE

IF "2" OR "5" ABOVE IS MARKED, CHECK APPROPRIATE ITEM(S) BELOW

1. (●) ENTIRE FACILITY 2. ( ) DISTINCT PART OF (SPECIFY) _____

3. [ ] IF DISTINCT PART OF HOSPITAL, IS HOSPITAL ACCREDITED?
a. ( ) YES b. (●) NO

6. BED COMPOSITION				
a. TOTAL NO. OF BEDS IN THE FACILITY 89	b. NUMBER OF HOSPITAL BEDS CERTIFIED FOR MEDICARE 0	c. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICARE 89	d. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICAID 89	e. NUMBER OF NF or ICF/MR BEDS CERTIFIED FOR MEDICAID 0

7. A. (●) THE FACILITY MEETS, BASED UPON (CHECK ALL APPROPRIATE BOXES)

1. (●) COMPLIANCE WITH ALL PROVISIONS 2. ( ) ACCEPTANCE OF A PLAN OF CORRECTION 3. ( ) RECOMMENDED WAIVERS 4. ( ) FSES 5. ( ) PERFORMANCE BASED DESIGN

B. ( ) THE FACILITY DOES NOT MEET THE STANDARD
K9

SURVEYOR (Signature)	TITLE	OFFICE	DATE
SURVEYOR ID 25822 K10	Deputy State Fire Marshal	State Fire Marshal	11/05/2013
FIRE AUTHORITY OFFICIAL (Signature)	TITLE	OFFICE	DATE
	Fire Safety Supervisor	State Fire Marshal	11-19-13

ID PREFIX		MET	NOT MET	N/A	REMARKS
	PART I - LSC REQUIREMENTS - Items in italics relate to the FSES **BUILDING CONSTRUCTION**				K11 - 2 hour building separation between Chapel Type V building and Nursing home Type II.
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	◉	○	○	
K12	2000 EXISTING 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				

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)	Not over two stories with complete automatic sprinkler system.
5		V (111)	
6		IV (2HH)	
7		II (000)	
8		III (200)	Not over one story with complete automatic sprinkler system.
9		V (000)	

☐ 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.

ID PREFIX			MET	NOT MET	N/A	REMARKS
K12	2000 NEW Building construction type and height meets one of the following: 18.1.6.2, 18.1.6.3, 18.3.5.1.		◉	○	○	
	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)	Not over one story with complete automatic sprinkler system.				
	4 ◉ V (111)					
	5 ○ IV (2HH)					
	6 ○ II (000)					
	7 ○ III (200)	Not Permitted				
	8 ○ V (000)					
	☐ 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 PREFIX		MET	NOT MET	N/A	REMARKS
	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 1/28 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* B	○	○		
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* B	○	○		

ID PREFIX		MET	NOT MET	N/A	REMARKS
K16	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	2000 EXISTING 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				
	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		MET	NOT MET	N/A	REMARKS
	VERTICAL OPENINGS				K21 - Magnetic Door hold opens, that have full corridor smoke detection, that is interconnected with the building fire alarm system.
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.	○	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	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	○	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K27	2000 EXISTING Doors in smoke barriers have at least a 20 minute fire protection rating or are at least 1¾ inch thick solid bonded core wood. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors shall be self-closing or automatic-closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7				
	2000 NEW Doors in smoke barriers have at least a 20 minute fire protection rating or are at least 1¾ inch thick solid bonded core wood. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Swinging doors shall be arranged so that each door swings in an opposite direction. Doors shall be self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8	○	○	○	
K28	2000 EXISTING Door openings in smoke barriers shall provide a minimum clear width of 32 inches (81 cm) for swinging or horizontal doors. 19.3.7.7				
	2000 NEW Door openings in smoke barriers are installed as swinging or horizontal doors shall provide a minimum clear width as follows: 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	○	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K104	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				
K29	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	Automatic Sprinkler	Separation	N/A
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			

Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.

ID PREFIX		MET	NOT MET	N/A	REMARKS
	2000 NEW Hazardous areas are protected in accordance with 8.4. The areas shall be enclosed with a one hour fire-rated barrier, with a ¾ hour fire-rated door, without windows (in accordance with 8.4). Doors shall be self-closing or automatic closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, 18.3.5.1.				

Area	Automatic Sprinkler	Separation	N/A
a. Boiler and Fuel-Fired Heater Rooms	✓	✓	
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 hazardous areas that are deficient in REMARKS.

K30	Gift shops shall be protected as hazardous areas when used for storage or display of combustibles in quantities considered hazardous. Non-rated walls may separate gift shops that are not considered hazardous, have separate protected storage and that are completely sprinkled. Gift shops may be open to the corridor if they are not considered hazardous, have separate protected storage, are completely sprinklered and do not exceed 500 square feet. 18.3.2.5, 19.3.2.5				

Area	Automatic Sprinkler	Separation	N/A
L. Gift Shop storing hazardous quantities of combustibles			✓

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.				

ID PREFIX		MET	NOT MET	N/A	REMARKS
	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				

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.)	○	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
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				
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 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				

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	○	○	○	K54 - The facility has full corridor smoke detection, with smoke detection in areas open to the corridor, that are interconnected to building fire alarm system, that has automatic notification to the fire department.
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 ☐ Bath				
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 PREFIX		MET	NOT MET	N/A	REMARKS
	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				
K60	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				
K56	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.	○	○	○	
K154	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. 10/11/2013				

ID PREFIX		MET	NOT MET	N/A	REMARKS
	B. Show who provided the service. Gerry				
	C. Note the source of water supply for the automatic sprinkler system. City Water				
	(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 international 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 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.	○	○	○	K67 - Documentation review of the fire damper testing log for the past 4 years revealed, all of the fire/smoke dampers have not been tested with-in the last 4 years. Last documented test was on 9/9/2009.
	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 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				

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 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	○	○	○	
K74	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.	○	○	○	
K75	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/ft^2 (20.4 L/m^2). A	○	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	capacity of 32 gal (121 L) shall not be exceeded within any 64-ft^2 (5.9-m^2) 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	○	○	○	
	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 PREFIX		MET	NOT MET	N/A	REMARKS
	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)	○	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K142	All occupancies containing hyperbaric facilities shall comply with NFPA 99, Standard for Health Care Facilities, Chapter 19.	○	○	○	
K143	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				
K106	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)	○	○	○	
K107	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	◉	○	○	
K144	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)	○	○	○	
K145	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 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	Office	Date
Fire Authority Official *(Signature)*	Title	Office	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 CONSTRUCTION

TOTAL NUMBER OF BUILDINGS _____

NUMBER OF THIS BUILDING _____

☐

A BUILDING
B WING
C FLOOR
D APARTMENT UNIT

LSC FORM INDICATOR

Health Care Form		
12	2786R	2000 EXISTING
13	2786R	2000 NEW

ASC Form		
14	2786U	2000 EXISTING
15	2786U	2000 NEW

ICF/MR Form		
16	2786V, W, X	2000 EXISTING
17	2786V, W, X	2000 NEW

* K7 ☐ SELECT NUMBER OF FORM USED FROM ABOVE

COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21

SMALL (16 BEDS OR LESS)

K8: ☐ 1 PROMPT 2 SLOW 3 IMPRACTICAL

LARGE

K8: ☐ 4 PROMPT 5 SLOW 6 IMPRACTICAL

APARTMENT HOUSE

K8: ☐ 7 PROMPT 8 SLOW 9 IMPRACTICAL

(Check if K29 or K56 are marked as not applicable in the 2786 M, R, T, U, V, W, X and Y.)

K29: ☐ K56: ☐

ENTER E – SCORE HERE

K5: ☐ e.g. 2.5

*K9: FACILITY MEETS LSC BASED ON *(Check all that apply)*

A1. ☐ (COMP. WITH ALL PROVISIONS)

A2. ☐ (ACCEPTABLE POC)

A3. ☐ (WAIVERS)

A4. ☐ (FSES)

A5. ☐ (PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC

B. ☐

K0180

A. ☐ FULLY SPRINKLERED (All required areas are sprinklered)

B. ☐ PARTIALLY SPRINKLERED (Not all required areas are sprinklered)

C. ☐ NONE (No sprinkler system)

* MANDATORY

PROJECT NUMBER:	PROVIDER NAME	SURVEY DATE
F5304023	ANGELS CARE CENTER	11/05/2013

Administrator: Kristi Umberger | Phone Number: (507)263-4658

Email address: kristi.umberger@voa.org

State Fire Inspector: Gary Schroeder # 76

These are preliminary findings only. A complete and final Statement of Deficiencies 2567 report will be provided by US Mail.

☐ **At the time of this inspection, this facility was found to comply with the requirements of the 2000 Life Safety Code applicable to:** ☑ **SNF/NF** ☐ **Hospital** ☐ **ICFMR** ☐ **ASC Facilities participating in the Medicare/Medicaid programs.**

☑ **The following fire/life safety deficiencies were found during this inspection:**

K TAG S& S	☑ **Draft Summary of Deficiency(ies)** ☐ **Revisit** ☐ **Clearance**
K67 S/S=F	No documentation that the fire and or smoke dampers have been tested with-in the last 4 years. Last date tested was 9/9/2009

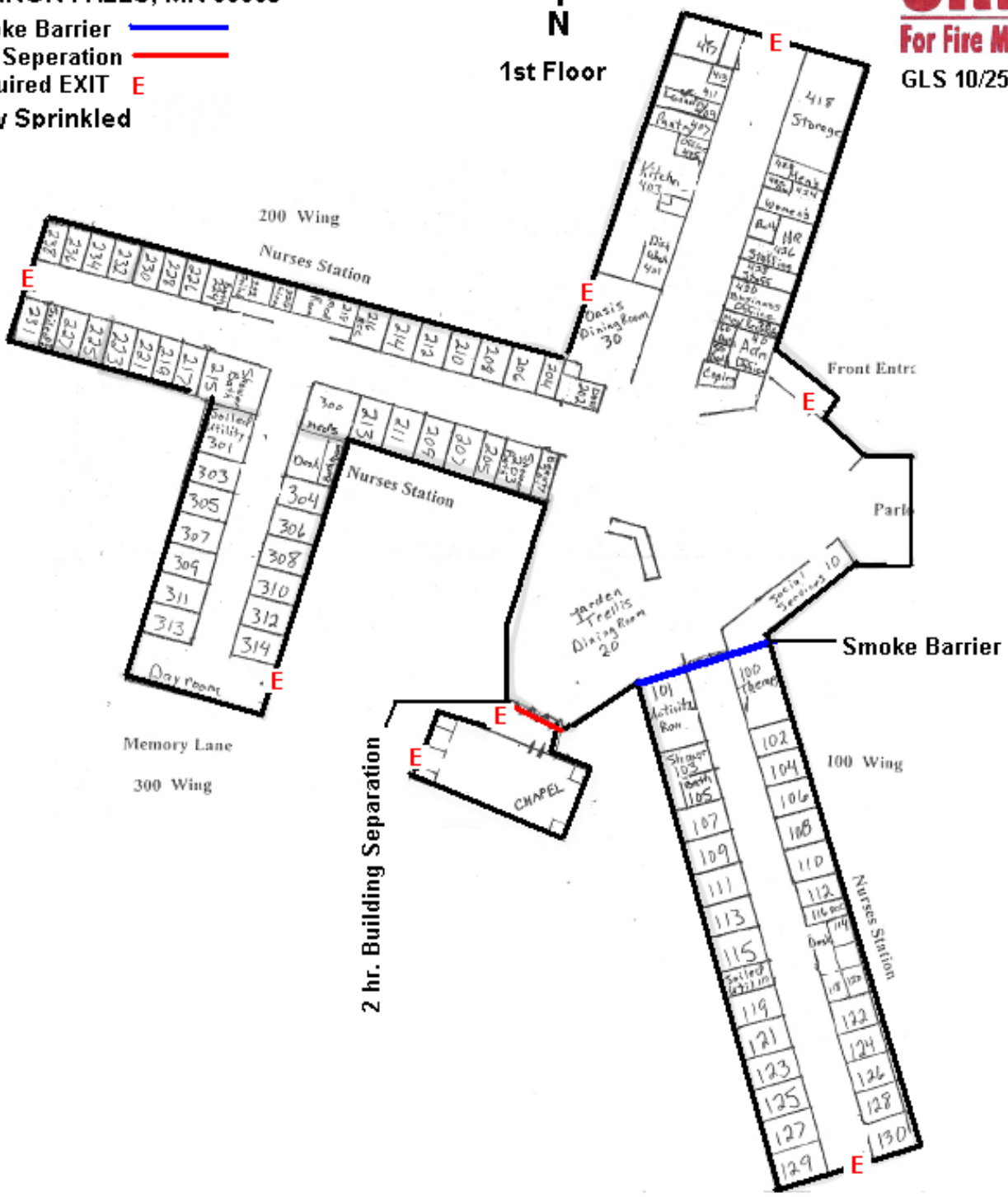
ANGELS CARE CENTER
300 NORTH DOW STREET
CANNON FALLS, MN 55009

Smoke Barrier
Fire Seperation
Required EXIT E
Fully Sprinkled

N

1st Floor

ORIGINAL
For Fire Marshal Division File
GLS 10/25/2011



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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: ETLH

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

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245304**

2.STATE VENDOR OR MEDICAID NO.
(L2) **908108900**

3. NAME AND ADDRESS OF FACILITY
(L3) **ANGELS CARE CENTER**
(L4) **300 NORTH DOW STREET**
(L5) **CANNON FALLS, MN** (L6) **55009**

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/08/2013** (L34)

8. ACCREDITATION STATUS: ___ (L10)

0 Unaccredited 1 TJC
2 AOA 3 Other

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **89** (L18)

13.Total Certified Beds **89** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	89			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Gail Sorenson, HFE NE II 01/14/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 02/26/14 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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;

<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)

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

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

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.

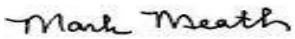
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

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

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

Sincerely,



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____ DEC 24 2013 MN Dept of Health	11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS CARE CENTER	300 NORTH DOW STREET CANNON FALLS, MN 55009

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A complaint investigation/s had been completed at the time of the standard recertification survey. Investigation/s of complaint H5304018 had been completed and had been substantiated. Deficiency/s had been issued as a result of the substantiated findings at F241, F312, F353.	F 000		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to promote a dignified dining experience in the secured unit (Memory Lane) for 8 of 16 residents (R66, R63, R65, R38, R37, R73, R82 and R56) observed during a meal. Findings include: R66 was not assisted to eat while other residents at the table ate	F 241	Accepted by Gloria Dahlen on 12/24/13 GPN/GD **F Tag 241 Dignity** Resident R66's careplan was reviewed and updated to include interventions for staff to assist at mealtime with cues, prompts and assistance as needed. R37's careplan was reviewed and updated to include interventions for staff to assist at mealtime with cues and prompts to keep resident awake and to assist with eating if needed. R65's careplan was reviewed and updated to include interventions for staff to put dentures in before meals and to provide cues, prompts and assistance with eating as needed. R63's careplan was reviewed	

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

Administrator 12-23-13

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.

GD per email 12-24-13
per telephone 12-31-13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 241	Continued From page 1 independently and when assisted to eat the food was not checked for warmth as it sat in the food cart and in front of R66 for a total of 37 minutes. R66 was admitted 6/24/2011 with a diagnosis of dementia, hallucinations, dementia with behavioral disturbance, esophageal reflux, legal blindness, panic disorder and depressive disorder. . A Quarterly Minimum Data Set assessment dated 8/12/2013 identified R66 as severely cognitively impaired and required extensive assist of one for eating. On 11/4/2013 12:12 p.m., the food cart arrived in the unit from kitchen. At 12:35 p.m., R66 received their food tray which had been uncovered. There were three other residents at this table and all three began to eat as soon as the meal was provided. R66 just watched the others eat until R66 picked up a plastic covered piece of bread and started chewing on it as the nurse had not removed the plastic from the sandwich when meal was set before R66. After the nurse had removed the plastic from the sandwich R66 make no attempt to eat independently. At 12:42 p.m., nurse manger (NM)-A sat next to R66 and began to assist R66 to eat. However, the food that had been delivered thirty minutes ago and sat uncovered for seven minutes was not warmed for the resident. On 11/6/2013, food trays arrived at 11:55 a.m. in the unit, R66 again received a tray uncovered 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 nursing assistant (NA)-F sat next to R66 at 12:43 p.m.	F 241	and updated to include interventions for staff to provide cues, prompts, redirection and assistance as needed at mealtime. R38's careplan was reviewed and updated to include interventions for staff to assist at mealtime with cues, prompts and assistance as needed. R73's careplan was reviewed and updated to include interventions for staff to prepare resident for meals and provide redirection, prompts, cues and assistance as needed. R82's careplan was reviewed and updated to include prompts for staff to redirect and provide assistance as needed at mealtime. R56's careplan was reviewed and updated to include interventions for staff to redirect and provide cues and assistance as needed at mealtime. In addition, the following interventions will be implemented on the 300 wing. 1. Meal trays will be placed in the food cart according to seating, not by diet. 2. A current seating chart will be maintained by the Nurse Manager for all meals. 3. The Nurse Manager or Charge Nurse for the unit will be responsible for calling for additional assistance at meal time if needed. 4. All staff will be re-educated on the correct procedures to be used during meal service, including: completing one	

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F 241	Continued From page 2 Again the food sat on the table uncovered for 28 minutes and had been in the food cart for 20 minutes prior to being set in front of R66. On questioning NA-F at 12:43 in regards to the food being cool NA-F said that she felt the food was still warm and made no attempt to test the food for temperature or warm the food for R66. R63 was not 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. Admitted: 5/6/2011 with diagnoses this included but not limited to: senile dementia. A quarterly MDS dated 9/6/2013 identified resident as severely cognitively impaired and required supervision and cueing after set up of meal. On 11/6/2013 at 11:55 a.m., the food cart had arrived from the kitchen. The menu was Tater Tot Hotdish, rutabagas and chocolate chip dessert. At 12:15 p.m., R63 received a meal tray that had been uncovered. 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 R63 to eat the meal when it was set in front of her or to use a fork to eat the cake. R63 began 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 warm at the time R63 began to eat the foods. During the entire meal service for R63 there was a nursing assistant seated at the same table helping R37 to eat their meal.	F 241	table before starting another, creating a calm, quiet environment, washing hands before and after meals, keeping plates covered, and offering assistance to residents as needed. 5. A management staff person will be assigned to the 300 wing at meal time to monitor and assist as needed. The DON, Nurse Managers and the Dietary Manager will implement measures to ensure that all residents in all dining rooms will be assisted as needed, and that the dining experience is pleasant and dignified. See interventions noted above and below. The procedure for meal assistance in all dining rooms will be reviewed and updated and staff will be educated on 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 at a table will all be served before starting the next table; Staff will intervene if there are disruptions during the meal; Residents will be offered cueing, prompting and assistance as needed; steps will be taken to ensure food is served at the correct temperature.	

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	245304	A. BUILDING _____ B. WING _____ DEC 24 2013 MN Dept. of Health Rochester	11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 241	Continued From page 3 R65 had been observed to not wear lower denture during meal and no staff attempted to encourage her to do so. R65 held the denture in her hand while attempting to use fork with the same hand. R65 had diagnoses which included: senile dementia, altered mental status and depressive disorder. R65's annual MDS assessment dated 10/11/2013 identified R65 as severely cognitively impaired and required supervision and cueing of one staff for eating. On 11/6/2013 at 11:55 a.m., the food cart arrived to the dining area of memory lane. The menu was Tater tot Hotdish and rutabagas and chocolate chip dessert. At 12:01 p.m. R65 received a food tray of regular textured food. The resident used a fork and started to eat with the left hand. The resident was observed to be clutching their lower dentures in the left hand while holding the fork to eat. At 12:12 p.m., R65 started eating the cake using her fingers. At 12:21 p.m., R65 use her fingers to remove some of the cake she just put into her mouth and placed it back in the bowl. At 12:27 p.m., R65 was done eating and was still holding the bottom dentures which she had during the entire meal. During the entire meal for R65 no staff encouraged her to use her bottom denture to eat the meal nor had they encouraged her to use the fork to eat the foods provided. R65 was not noted to have a problem with coughing while eating the few bites of food she took. On 11/7/2013 at 8:30 a.m., a licensed practical nurse (LPN)-D was interviewed regarding R65 ' s	F 241	A review of the revised procedures by the Medical Director/Quality Assurance Committee will be conducted to determine if procedures meet current standards of practice. Nursing staff were re-educated on 11/27/13. All staff will be re-educated by 12/18/13. The Director of Nursing, Nurse Managers and the Dietary Manager will monitor the corrective actions to ensure the effectiveness of these actions, including: Conduct random meal observation audits to ensure adherence to procedures for meal times. Audits will be done 3 times weekly at different meals and in all dining rooms for 3 months. The 300 wing Nurse Manager will be responsible for monitoring the evening meal in all dining rooms and will provide re-education as needed and report issues to the DON and/or Administrator. Upon completion of reviews/audits, corrective actions, if applicable will be completed immediately. Additional education will be provided as derived	

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F 241	Continued From page 4 not using the bottom dentures while eating the meal on 11/6/13 at noon. LPN-D indicated R65 would take dentures out of mouth and put them in when the resident wanted. LPN-D said that staff is to encourage R65 to wear dentures while eating. R65 was observed at 8:30 to be eating while holding denture in her left hand. After informing LPN-D of R65 holding onto denture LPN-D approached R65 and asked her put her denture back in her mouth. R65 nodded yes and LPN-D put the denture in R65 ' s mouth and R65 made no attempt to remove the denture for the rest of the meal. R38 was not assisted during dining in a timely manner. A quarterly minimum data set assessment dated 10/6/2013 identified resident as severely cognitively impaired and required limited assist of one staff for eating. The resident had diagnoses which included: Alzheimer's dementia, aphasia, and depression. On 11/4/2013 at 12:12 p.m., the food cart arrived on memory lane unit from the kitchen. At 12:25 p.m., R 38 was given a tray of food uncovered and the resident started playing with the bib in the food. The resident made no attempt to eat and no staff assisted the resident. At 12:42 p.m., a nurse manger (NM)-A sat down by R38 and assisted the resident to eat. The resident ' s food sat on the food cart for 13 minutes and then sat on the table another 17 minutes before the resident was fed or assisted to start to eat. During that time, the resident continued to play with the bib in the food. Other residents at the table were eating. 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	F 241	from the reviews. Failure to adhere to educated protocols will result in corrective counseling. The results of monitoring of the corrective actions (track, trend and analysis) will be reported to the facility QA Committee monthly for 6 months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan. Audits will be reduced based on compliance and recommendations from the QA Committee. Facility DON and E.D. will be 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	11/08/2013

DEC 24 2013
MN Dept of Health
Rochester

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS CARE CENTER	300 NORTH DOW STREET CANNON FALLS, MN 55009

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F 241	Continued From page 5	F 241		

the food had not been checked for temperature before NA-C began assisting her to eat.

A quarterly MDS dated 9/5/2013 identified the resident as moderately cognitively impaired and required supervision and cueing of one staff for eating. Diagnoses included: malnutrition, depression, dementia, and stroke.

On 11/6/2013 at 11:55 a.m., the food cart arrived in the memory lane unit. R37 received a meal tray of food uncovered at 12:07 p.m. R37 was observed to be asleep in the wheelchair when the food arrived. NA-C went over to cue R37 to eat a couple of times, but the resident would doze off as soon as NA-C left. At 12:28 p.m., NA-C sat next to R37 and began to assist R37 to eat. This was 33 minutes after the food trays arrived in the unit and 21 minutes after R37 ' s food was placed uncovered in front of her. NA-C had not checked the food for temperatures and made no attempt to warm the foods.

R73 was not assisted in a timely manner during dining.

On 11/4/2013 at 12:12 p.m., the food cart arrived on the memory lane unit from the kitchen.
At 12:42 p.m., R73 had a tray of food put in front of her and it was uncovered. The food had been in the food cart for thirty minutes and had not been checked for temperature before serving to R73.

During dining observation on 11/4/2013 from 12:12 p.m. until 12:45 p.m., R73 was in a wheelchair with lap buddy on wheeling self around the dining room as other residents were

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DEC 24 2013
MN Dept of Health
Rochester

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS CARE CENTER	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 6 eating or waiting to be assisted to eat. R73 was singing loudly and for long periods of time until she was assisted to a table and encouraged to eat her meal at 12/42 p.m. During this time R82 was yelling at R73 to " Shut up! Shut up! " Then R56 would add to the yelling by saying, " Hello! Hello! " then R56 used her spoon to pound it loudly on the table. There were no staff interventions for any of these disruptive behaviors from residents making an unpleasant and disruptive dining experience for 16 of the 17 residents living on the unit as one resident at in the privacy of their bedroom. It was also observed at the start of the meal that no resident had their hands washed even though several had used their fingers to eat their foods. On 11/4/2013 at 1:45 p.m. and again on 11/7/2013 at 9:00 a.m., LPN-D was interviewed regarding dining observations on 11/4/13 at noon. LPN-D stated it had been normal for some of the residents to wait to eat because of the short staffing. LPN-D said that they usually staffed one nursing assistant and one nurse during the day shift for 17 residents who needed quite a bit of assistance. The residents are assisted to eat as soon as they can get around to them and the food is not always reheated for the residents who sat a long time waiting to be assisted to eat. LPN-D said that the staff wasn ' t always able to cue the residents as they should have been to eat their meal or to be able to monitor behaviors closely during dining because it was too busy during the dining meal to just get residents assisted to eat.	F 241		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged	F 280	**F Tag 280** The IDT reviewed resident # R56's care plan and documentation related to recent falls and made revisions to the care plan and care assignment sheet. Revision included an intervention to remind the resident's husband not to transfer resident for safety reasons. Nurse Manager reviewed care plan changes with family.	

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F 280	Continued From page 7 incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared 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, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to update the care plan interventions related to falls for 1 of 3 residents (R56) reviewed for falls and failed to develop care plan interventions to address non-English speaking communication needs for 1 of 1 resident (R78) who only understood Spanish. Findings include: R56 had frequent falls and the facility had assessed that family (F)-A had been assisting R56 when the falls had occurred. However, the intervention to remind F-A to seek staff help if R56 needed to be transferred had not been included in the care plan for staff to be aware of this concern and intervention.	F 280	The Director of Nursing and Nurse Managers will implement corrective actions for other residents potentially affected by this practice including: identification via comprehensive record review specific to falls. All residents will be reviewed at care conference and/or with significant changes, including increased falls. The Director of Nursing or designee will implement measures to ensure that this practice does not recur, including: Re-education of nursing staff on the policies and procedures related to falls. Nursing staff was educated on 11/27/13. A review of the revised policies and procedures by the Medical Director will be conducted to determine if policies meet current standards of practice. The Director of Nursing and /or designee will monitor the corrective actions to ensure the effectiveness of these actions, including: Weekly audits of 3 resident charts that have had falls. The IDT reviewed resident # R78's care plan and documentation related to	

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F 280	Continued From page 8 On 11/6/13 at 8:00 a.m. R56's F-A had been observed to push R56 in the wheelchair while visit. R56 had diagnoses that included dementia, history of rib fracture, femur fractures, and vertebra fractures. Incident in notes dated 9/25/13 read that R56 was found on floor on knees holding the bed. Predisposing factors included gait imbalance and impaired memory. No injury was noted. Incident in notes dated 10/13/13 R56 was found on floor next to the bed. R56 complained of right hip pain, but had no difficulty with range of motion. The quarterly Minimum Data Set dated 10/22/13 indicated R56 was severally cognitively impaired and required extensive assistance with transfers, bed mobility and did not walk. Fall Risk Assessment dated 7/19/13 indicated R56 was at moderate risk for falls related to cognitive deficits, poor decision making, urinary incontinence, a history of pain with weight bearing, medications, and a history of agitated behaviors. R56 ' s care plan undated identified a problem of impaired mobility with risk for falls related to dementia, hypertension, osteoarthritis, self-transfers as evidenced by a history of falls, decreased safety awareness, need assist with mobility. The care plan lacked an intervention or reminding the spouse not to help the resident transfer. Nursing Assistant (NA)-B was interviewed on 11/8/13 at 9:49 a.m. NA-B stated she thought that sometimes F-A had been trying to transfer	F 280	communication and made revisions to the care plan and care assignment sheet. Revision included adding use of communication cards to residents care plan. Interpreter services will be offered Social Service will implement corrective actions for other residents potentially affected by identifying other residents with possible language barrier. All residents will be reviewed at admission for language barrier. Interpreter services or communication tools will be arranged and care planned as appropriate. Social Services will ask prior to admission if new residents have any language barrier and proper communication services will be arranged. Social Services will audit residents once a month for 6 months to ensure proper communication is being offered. Upon completion of reviews/audits, corrective actions, if applicable will be completed immediately. Additional education will be provided as derived from the reviews. Failure to adhere to	

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F 280	Continued From page 9 R56. Staff then tries to intervene if they see this happen. NA-B stated she has never seen R56 attempt to transfer self. Clinical Manager (CM)-B was interviewed at 11:00 a.m. on 11/8/13. CM-B stated R56 had been falling a lot, but now that F-A had not been transferring R56 alone as much, R56 was not falling. CM-B stated F-A liked to help C56 as much as possible and needed reminders by staff not to help transfer R56 alone as R56 falls when this occurs. During an interview on 11/8/13 at 12:20 p.m. the director of nursing verified R56 ' s care plan did not include an intervention related to reminding F-A not to transfer R56 and get help if R56 needs to be moved or transferred. R78 had been assessed to not understand English as a spoken language or as a written language as they only understood Spanish. R78 had been admitted on 6/4/13. R78 had diagnoses that included but not limited to anoxic brain damage, aphasia. R78's significant change Minimal Data Set (MDS) dated 10/15/13 identified preferred language Spanish, no speech, rarely/never understood. R78's care area assessment (CAA) worksheet dated 10/21/13, identified nature of the problem/condition: essentially non-verbal related to anoxic brain damage, aphasia, primary language Spanish and characteristics of the communication impairment. R78's care plan review date 10/22/13, identified vulnerable adult as depends on staff for all cares and is unable to communicate with only intervention of use interpreter. R78's care plan	F 280	educated protocols will result in corrective counseling. The results of monitoring of the corrective actions (track, trend and analysis) will be reported to the facility QA Committee monthly for 6 months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan. Audits will be reduced based on results and recommendations from the QA Committee. Facility DON and E.D. will be 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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F 280	Continued From page 10 had no other interventions to promote communication needs. R78's therapeutic recreation summary dated 10/15/13 identified primary language Spanish. During observation on 11/4/13, at 1:09 p.m., activities-A had been in R78's room talking to R78 in English and had stated to surveyor R78 does not speak English, R78 looks at you but does not talk. She had stated R78's language was Spanish. The television had been on in R78's room and had been on the Spanish channel for R78 to watch. During interview on 11/7/13, at 8:44 a.m., social service person stated R78 does not speak English, is non-verbal and speech therapy had not worked with R78 regarding language barrier and communication. Social service stated she had talked about interpreter with family, not sure what they want to do. During interview on 11/7/13, at 12:55 p.m., nursing assistant (NA)-E stated I do not speak Spanish. NA-E stated I talk to R78 in English and use hand gestures. NA-E stated staff development gave a sheet with some simple English words converted to Spanish for us to use. However, this was not used routinely and not part of the care plan. During interview on 11/7/13, at 2:00 p.m., speech therapist stated she provided swallow therapy only for R78. Speech therapist stated she had tried some communication in Spanish with R78 and there was no response. Speech therapist verified there is no documentation in therapy notes regarding communication and had not	F 280		

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F 280	Continued From page 11 given anything to staff to use for communication. Speech therapist verified R78 understands and 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 communicate and involve family to communicate. Director of nursing stated she would expect communication to be care planned.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide eating assistance as assessed and care planned for 1 of 3 residents (R21) reviewed for nutritional services. Findings include: R21 had not been assisted with meals or snacks according to R21's plan of care. R21 had been admitted on 8/22/13 with diagnoses that included but not limited to diabetes, protein-calorie malnutrition. R21 ' s admission Minimum Data Set (MDS) dated 8/29/13, indicated R21 had a brief interview for mental status (BIMS) score of five, which is severe cognitive impairment.	F 282	Resident # R21 identified in this statement of deficiency has been reassessed for ability to feed self. Corresponding updates have been made to the care plan, care assignment sheet and communicated to the resident and/or designated decision maker. All staff responsible for care for the resident has been educated on notification protocols including notification of the Nurse Manager if the care plan or care card does not accurately reflect the care currently needed by the resident. Education was done on 11/27/13. The Director of Nursing and/or designee will implement corrective actions for other residents potentially affected by this practice including: identification via comprehensive record review specific to assistance	

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F 282	Continued From page 12 R21's care plan revision dated 11/1/13, indicated: nutrition alteration per cognitive changes, need for consistency altered meats, one assist with meals and interventions: diet per physician orders, eating one assist to eat all meals. 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, carbohydrate 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 the hall/lobby area from dining room located by kitchen and R21 had been independently eating lunch. Dietary staff approached R21 once and asked R21 if doing o.k. and R21 had replied " Yeah. " 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 quarters of juice. No staff person had sat with R21 during entire meal to assist or cue R21 to complete the meal. During observation on 11/7/13, at 7:19 a.m., R21 had been sitting in dining room located across hall/lobby area from dining room located by kitchen independently eating breakfast. R21 had an eight ounce glass of juice, cereal bowl of malt-o-meal. R21 had stated at 7:29 a.m., I have to go to the bathroom and left dining room. R21 had consumed approximately three quarters of	F 282	needed with eating and other ADL's. Residents will be reviewed at care conference and with significant changes. The Director of Nursing and/or designee will implement measures to ensure that this practice does not recur, including: Re-education of nursing staff on policy and procedures for reporting changes in resident condition and/or care plan/care card, and re-education on use of the temporary care plan. Nursing staff were trained as it relates to their respective roles and responsibilities for the aforementioned policies and procedures on November 27, 2013. The Director of Nursing and /or designee will monitor the corrective actions to ensure the effectiveness of these actions, including: Audits of 3 care plans per week x 3 months. Upon completion of reviews/audits, corrective actions, if applicable will be completed immediately. Additional education will be provided as derived from the reviews. Failure to adhere to educated protocols will result in	

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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 R21 needs more assistance lately, had not been 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	corrective counseling. The results of monitoring of the corrective actions (track, trend and analysis) will be reported to the facility QA Committee monthly for 6 months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan. Audits will be reduced based on results and 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 standard indicated by 12/18/13.	12/18/13

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F 282	Continued From page 14 meals. 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." 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 CAN [NA].	F 282		
F 285 SS=D	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of	F 285	Resident # R10 identified in this statement of deficiency has been reassessed for PASRR Level II screen. Corresponding updates have been made to the care plan, care assignment sheet and communicated to the resident and/or designated decision maker. Social Services will request Level II screens on each appropriate resident that stays long term. They will audit once a month for 6 months and report to QA on all new long term residents that the proper screen was completed.	

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F 285	Continued From page 15 services, whether the individual requires specialized services for mental retardation. (ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission-- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. For purposes of this section: (i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1). (ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the comprehensive level II preadmission screening and psychosocial and/or rehabilitative assessment as required to determine mental health rehabilitative services needed for 1 of 1 residents (R10) reviewed for Preadmission Screening and Resident Review (PASRR) Level II screening. Findings include: R10 lacked a level II PASRR concerning their specialized needs for mental illness and intellectual disability services.	F 285	Facility Social Worker will be 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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F-285	Continued From page 16	F-285		

The facility identified R10 as a resident with intellectual disability. The facility also identified R10 as having a Level II PASRR screening.

The medication consent form sated 12/4/12 indicated R10 had schizophrenia a mental illness. R10 ' s diagnosis provided from the facility included depression, anxiety, paranoid schizophrenia, and moderate intellectual disability.

The PASRR dated 10/12/04 indicated R10 would reside in the facility for less than 30 days. This PASRR was updated on 11/24/04 to less than 90 days in the facility. A note indicated R10 was " admitted 10/12/04 stay was thought to be <30 days but now will be <90 days. Will hopefully be D/C ' d [discharged] in couple of weeks ... " " SW [social worker] says probably no 'active treatment '." The Level I Screening for Mental Illness or Mental Retardation (changed to Intellectual disability) indicated that this form was to be completed for any admission to a medical assistance certified nursing facility. The Level I screening form indicated R10 did have a major mental illness diagnosis but did have impaired functioning. The Level I screening did not note if R10 had a psychiatric treatment history as a question mark was placed in the box of this question. The Level I screening also noted R10 had intellectual disability, had presenting evidence of cognitive or behavioral issues that may indicate the presence of intellectual disability.

During an interview on 11/8/13 at 10:40 a.m. the licensed social worker (LSW) stated she did not have a copy of the Level II PASRR screening for R10. At 11:30 a.m. LSW stated she had placed a

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F 285	Continued From page 17 call to the County trying to find a copy of a Level II screening. No copy of a Level II screening was provided.	F 285		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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 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.) Findings include: R47 lacked assistance for trimming and cleaning 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	F 312	Residents R47, R56, and R65, identified in this statement of deficiency have been checked and had their nails cleaned and trimmed as needed. Corresponding updates have been made to the care plan, care assignment sheet and communicated to the resident and/or designated decision maker emphasizing nail care to be done on bath days. The Nurse Manager on the 300 wing will conduct on-going random audits to ensure compliance with nail care being done on a regular basis. Staff will receive re-education on problem areas. R21 has been reassessed for ability to feed self. Corresponding updates have been made to the care plan, care assignment sheet and communicated to the resident and/or designated decision maker. All staff responsible for care for the resident have been educated on notification procedure including notification of the Nurse Manager if the care plan or care card does not accurately reflect the care currently needed by the resident. Education was done on 11/27/13. The Director of Nursing and Nurse Managers and/or designee will implement	

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F 312	Continued From page 18 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 hygiene. The care area assessment (CAA) dated 6/19/13 indicated R47 lived on the memory unit and had diagnoses that included dementia, anxiety, depression, osteoarthritis and history of hip fracture. The CAA noted R47 needed assistance with ADLs. The care plan dated 10/3/13 noted an intervention of " nail care after bathing as needed." The director of nursing (DON) was interviewed on 11/8/13 at 2:50 p.m. DON stated she was aware of F-A ' s concerns which were reported this last summer. DON stated she remembered concerns were about R47 ' s finger nails. DON stated they had been disappointed that F-A had the same concern a couple months later. R47 had been transferred to another home after F-A had complained of R47 not getting adequate cares. R56 lacked trimming and cleaning of finger nails. R56 was observed on 11/4/13 at 12:11 p.m. R56 was noted to have long and dark colored fingers nails on both hands. On 11/6/13 at 8:00 a.m. R56 was observed in the wheelchair. R56 ' s fingers nails were observed to remain long and soiled under nails on both hands. The quarterly MDS dated 10/22/13 was reviewed. The MDS indicated R56 was severely cognitively impaired and required extensive assistance of one for personal grooming and bathing. The care plan provided 11/6/13 identified a problem of self-care deficit in dressing, bathing, and grooming related to dementia and	F 312	corrective actions for other residents potentially affected by this practice including: An audit focused on grooming and nail care was completed by the Staff Development nurse for all residents. Results of the audits were communicated to the Nurse Managers who then followed up on all problems noted. A follow-up audit was done several weeks later to assess for improvement. Problems were reported to the Nurse Manager who then followed up on all problems identified. Identification of other residents potentially affected by this practice will be done via comprehensive record review specific to assistance needed with eating and other ADL's. Reviews will be done at care conferences and with significant changes. The Director of Nursing or Nurse Managers and/or designee will implement measures to ensure that this practice does not recur, including: Re-education of nursing staff on policy and procedure for reporting changes in resident condition and or care plan, and re-education on the use of the temporary care plan.	

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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 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 looking finger nails. On 11/7/2013 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 while eating breakfast eating with long dirty fingernails. 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 assistance to complete ADL's. Interventions:	F 312	Ongoing 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 indicated by 12/18/13.	12-18-13

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Bathing: 1 assist to complete. Encourage independence with upper body. Nail care after bathing as needed. Report any changes to the nurse. PERSONAL HYGIENE: 1 assist to complete, cue/encourage independence with upper body.

R65's MDS dated 10/11/2013 identified resident as severely cognitively impaired and required extensive assist of one staff for personal hygiene activities of daily living.

On 11/7/2013 at 1:15 p.m., nurse aide (NA) - G stated they were to do resident nails on bath days which were weekly.

On 11/8/2013 at 10:40 a.m., a clinical nurse manager (CNM)-B stated the staff should be checking finger nails every bath day and trim if needed.
The policy entitled Nails Care of (Finger and Toe) dated 2006 noted the purpose as to provide cleanliness, prevent spread of infection, comfort, to prevent skin problems. The procedure did not include the frequency of nail care. The facility policies entitled Bath (partial) dated 2006 and Bath (bed) dated 2006, directed staff to "care of fingernails and toenails is part of the bath."

R21 had not been assisted with meals or snacks according to R21's plan of care.

R21 had been admitted on 8/22/13 with diagnoses that included but not limited to diabetes, protein-calorie malnutrition, and carcinoma of prostate. R21's admission Minimum Data Set (MDS) dated 8/29/13, indicated R21 had a brief interview for mental status (BIMS) score of five, severe cognitive impairment.

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R21's care plan revision dated 11/1/13, indicated focus: nutrition alteration per cognitive changes, need for consistency altered meats, one assist with meals and interventions: diet per physician orders, eating one assists to eat all meals.

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 quarters of juice. No staff person had sat with R21 during entire meal to assist R21.

During observation on 11/7/13, at 7:19 a.m., R21 had been sitting in dining room located across hall/lobby area from dining room located by kitchen independently eating breakfast. R21 had an eight ounce glass of juice, cereal bowl of malt-o-meal. R21 had stated at 7:29 a.m., I have to go to the bathroom and left dining room. R21 had drunk approximately three quarters of juice and eaten three quarters of malt-o-meal. Dietary staff person had asked R21 if finished with

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breakfast before exciting dining room and R21 had stated I guess so. No staff person had sat with R21 during entire meal to assist R21.

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 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, 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

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F 312	Continued From page 23 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."	F 312	**F318** Resident # R52 identified in this statement of deficiency has been reassessed for services related to range of motion and updates were made to the care plan and care card as needed by the Nurse Managers. Nursing staff was re-educated on 11/27/13 on the importance of following the residents' plan of care, which includes any restorative nursing orders or recommendations. Education was also done on the importance of consistently charting cares, including any restorative programs or recommendations from therapy or nursing. The Nurse Managers have reviewed the charts and care plans for any resident with a Range of Motion program or with assistive devices currently being used and made changes to the care plans and care cards as needed. Nursing staff was re-educated on 11/27/13 on the importance of following the residents' plan of care, which includes any restorative nursing orders or recommendations. Education was also done on the importance of charting cares, including any restorative programs or recommendations from therapy or nursing.	
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide range of motion services (ROM) as recommended by the physical therapist for 1 of 3 residents (R52) reviewed for range of motion services. Findings include: R52 did not receive the range of motion services or use the hand/finger splint as recommended by the physical therapist. R52 was observed on 11/4/13 at 2; 45 p.m. lying in bed and on 11/05/2013 at 02:47 p.m. R47 was observed sitting in the wheelchair. When asked to open right hand, R57 was unable to straighten out fingers on right hand. No splint had been present. During observations on 11/7/13 from 8:30 a.m. to 9:00 a.m., R52 was observed during morning cares receiving assistance with personal	F 318		

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F 318	Continued From page 24 hygiene and dressing. R52 could move all upper extremity joints to some extent and was able to transfer with the E-Stand lift. R52 did not utilize a right hand splint and no range of motion was provided or offered during this time. During an interview on 11/7/13 at 11:12 a.m. R52 stated no range of motion to contracted right hand had been done by staff. R52 stated that staff had done range of motion to leg as R52 moved right leg back and forth. During an interview on 11/7/13 at 11:15 a.m. nursing assistant (NA)-A stated that the contracted hand should be washed with morning cares, but no range of motion is done because 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	F 318	The Director of Nursing and/or designee will implement measures to ensure that this practice does not recur, including routine monitoring of the resident's restorative programs/recommendations by the Nurse Managers to ensure on-going compliance. Resident's mobility needs will be reviewed quarterly at care conference and IDT meetings. In addition, random audits will be done at least 3 times weekly for 3 months on residents receiving a restorative program or assistive device to determine compliance. The Director of Nursing and /or designee will monitor the corrective actions to ensure the effectiveness of these actions, including: Upon completion of reviews/audits, corrective actions, if applicable, will be completed immediately. Additional education will be provided as derived from the reviews. Failure to adhere to educated protocols will result in corrective counseling. The results of monitoring of the corrective actions (track, trend and analysis) will be reported to the facility QA Committee monthly for 6 months. Upon this review, system revisions and/or staff education	

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F 318	Continued From page 25 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.	F 318	will be implemented if indicated via a prescribed corrective action plan. Audits will be reduced based on compliance and recommendations from the Medical Director and QA Team.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and documents, the facility failed to thoroughly investigate an injury and develop interventions to minimize recurring accidents for 1 of 3 residents (R67) reviewed for accidents. Findings include: R67 had injury of unknown origin resulting in a fracture to the index finger of left hand. However, the incident had not been thoroughly investigated to determine causal factors and based on this investigation interventions had not been developed to minimize or prevent further occurrences. Incident report dated 9/28/2013 and time of 13:14 (1:14 p.m.) for R67 was reviewed. A nurse reported that R67 had a swollen index finger on left hand with discoloration to site. The resident was unable to describe how injury happened and		Facility DON will be responsible for maintaining compliance. The facility alleges that it will be in substantial compliance with the standard indicated by 12/18/13.	
		F323	The IDT reviewed R67's recent falls/incidents and charting to determine problems or inconsistencies or if further investigation was indicated. Corresponding updates have been made to the care plan and care assignment sheet and communicated to the resident and/or designated decision maker. Staff responsible for the care of the resident have been re-educated on the policy and procedure for reporting and investigating incidents. The Director of Nursing and/or designee will implement corrective actions for other residents potentially affected by this practice including: a review of resident records for those residents who have had recent falls or injuries was completed to determine problems or inconsistencies or if further investigation is indicated. Further follow-up will be done as indicated and the care plan and care card will be updated. The Director of Nursing and/or designee will implement measures to ensure that this	

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F 323	Continued From page 26 had some pain. On 10/2/2013, nursing assistants interviewed and stated resident had not been combative in the last few days but does have history in the past. Nursing assistants report finger is on non-dominant hand and therefore would not have had to strike out hard enough to fracture finger. Resident unable to recall what happened but staff report resident would be able to call out or report if someone had hurt him. Due to the fact that finger is on weak side theory of cause is that arm dangled and got caught in wheelchair or rail. Resident unable to propel wheelchair but staff did not report resident had yelled out during transfer or in bed. Interdisciplinary team (IDT) reviewed incident for 9/28/2013 at 13:14. Incident reported to Office of Health and Facility Compliant and to Common Entry Point. R67's annual Minimum Data Set dated 8/6/2013 was reviewed and identified the resident with severe cognitive impaired and required extensive assistance of 2 staff to total assistance for activities of daily living. On 11/4/2013 at 2:09 p.m. and 3:02 p.m., a licensed practical nurse (LPN)-D was interviewed and identified R67 wore a splint on the left index finger. On asking LPN-D if they or the NA concerning R67 ' s fractured finger LPN-D said both her and NA-F didn't know how it happened. On 11/8/2013 at 9:50 a.m., a clinical nurse manager, registered nurse (RN)-B was interviewed regarding the incident. Said that R67 had not had a thorough investigation to determine possible reasons for the injury and did not put interventions in place to prevent further injury or new injuries from occurring.	F 323	practice does not recur, including: Ongoing weekly audits of at least 3 incident reports to determine compliance with the facility's policy and procedure for reporting and investigating of resident incidents. Immediate re-education of staff will be completed if problems or inconsistencies are found. The procedure for reporting and investigating incidents has been revised to provide more consistency and include more of the interdisciplinary team in the decision making process. Staff education was done on 11/27/13 to review the facility policy and procedure on reporting and investigating. The Director of Nursing or Administrator or Social Worker will monitor the corrective actions to ensure the effectiveness of these actions, including: Upon completion of reviews/audits, corrective actions, if applicable will be completed immediately. Additional education will be provided as derived from the reviews. Failure to adhere to educated protocols will result in corrective counseling. The results of monitoring of the corrective actions (track, trend and analysis) will be reported to the facility QA Committee monthly for 6months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan. Facility Director of Nursing and Social Worker will be 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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F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure use of non-pharmacological interventions had been attempted before the administration of as needed antianxiety medications and pain medications for 2 of 5 residents (R8, R56) and failed to assess for sleep disturbance for 1 of 5 residents (R8) reviewed for unnecessary medications.	F 329	Resident(s) R56 and R8 identified in this statement of deficiency have been reassessed for use of non-pharmacological interventions before administering PRN meds for pain and anxiety. Resident R8 was reassessed for use of non-pharmacological interventions before administering PRN sleep medications. Corresponding updates have been made to the care plan and care cards and communicated to the resident and/or designated decision maker. Nursing staff was educated on 11/27/13 on facility policy and procedure for offering non-pharmacological interventions prior to administering PRN medications for sleep, pain or anxiety and documenting interventions, to include effectiveness. The Director of Nursing, Nurse Managers and/or designee will implement the same corrective actions as noted above for all other residents potentially affected by this practice. Resident care plans will be updated quarterly and with significant changes and non-pharmacological preferences will be added to the care plans. The Director of Nursing or designee will implement measures to ensure that this practice does not recur, including revision of the EMAR, to include a pop-up reminder to offer non-pharmacologic	

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F 329	Continued From page 28 Findings include: R8 received as needed (PRN) pain medications (Tylenol and oxycodone) without first attempting non-pharmacological measures. R8 received antidepressant medication (Trazodone) for insomnia without being assessed for sleep quality. R8 had been admitted on 2/18/13. R8 had diagnoses that included but not limited to dementia, osteoarthrosis, depressive disorder, chronic pain. The quarterly Minimum Data Set (MDS) dated 8/20/13, indicated R8 had no trouble sleeping, received scheduled pain medication, received PRN medication, received non-medication interventions for pain, frequent pain and pain intensity score of 10. R8's brief interview of mental status (BIMS) had been 9 out of 15 on the MDS and indicated moderate cognitive impairment. During review of R8's current physician orders dated 10/30/13, revealed an order for oxycodone 5 milligrams (mg) every six hours PRN for breakthrough pain, Tylenol 650 mg every four hours PRN for pain and Trazodone 50 mg at bedtime for depression with insomnia. During review of R8's care plan review date 9/24/13, identified problem of impaired comfort and directed nurses to offer non-medication (or non-pharmacological) interventions such as warm packs, cool packs, repositioning, distraction techniques PRN. At risk for interrupted sleep and directed staff to encourage activities and activeness during day, limit caffeine intake after three p.m. and provide quiet sleep environment. Diagnosis of insomnia and use of antidepressant medication for sleep had not been addressed on the care plan.	F 329	interventions prior to administering a medication. A list of possible interventions is included. Medical Records or designee will be responsible for adding the reminder in the EMAR for all newly admitted residents. A review of the revised policy by the Medical Director and QA Committee will be conducted to determine if policies meet current standards of practice. All nursing staff was trained on 11/27/13 as it relates to their respective roles and responsibilities for offering non-pharmacological interventions, including non-pharmacological interventions appropriate for the Nursing Assistants to utilize. A list of non-pharmacological interventions, including suggestions from the Empira Restorative Sleep Vitality Program, will be available at each nursing station as a reference for all staff. The Director of Nursing, Nurse Managers and/or designee will monitor the corrective actions to ensure the effectiveness of these actions by completing audits on at least 3 residents every week to ensure non-pharmacological interventions are being utilized and documented.	

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F 329	Continued From page 29 During review of R8's medication administration record and progress notes of PRN medication documentation sheets the following had been noted from the dates of 10/4/13 through 10/31/13: R8 had had received a total of four doses of PRN Tylenol with no documentation of non-pharmacological interventions attempted prior to administration and two doses of PRN oxycodone with no documentation of non-pharmacological interventions attempted prior to administration for one of two doses. Review from the dates of 11/1/13 through 11/7/13: R8 had received a total of two doses of PRN Tylenol with no documentation of non-pharmacological interventions attempted prior to administration for one of two doses and four doses of PRN oxycodone with no documentation of non-pharmacological interventions attempted for three of four doses. During interview on 11/7/13, at 8:38 a.m., registered nurse (RN)-C stated should monitor hours of sleep for diagnosis of insomnia and when a medication is started for sleep. RN-C verified no sleep monitoring had been done for R8. 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 tried prior to administering	F 329	Upon completion of reviews/audits, corrective actions, if applicable will be completed immediately. Additional education will be provided as derived from the reviews. Failure to adhere to educated protocols will result in corrective counseling. The results of monitoring of the corrective actions (track, trend and analysis) will be reported to the facility QA Committee monthly for 6 months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan. Frequency of the audits will be reduced 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 standard indicated by 12/18/13.	12/18/13

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PRN pain medication and to document the non-pharmacological interventions.

Document review of facility PAIN EVALUATION AND MANAGEMENT dated 2010, read "POLICY It is the policy for Volunteers of America (VOA) that all residents have the right for appropriate pain assessment and pain management. All residents will be evaluated for indicators or a history of pain for the MDS 3.0 on admission, quarterly, with a significant change in status, and with new onset of potential pain or discomfort. Data will be collected through resident interviews, staff interviews and observations."

Surveyor had requested from facility a policy for sleep, none had been provided.

R56 received antianxiety medications as needed without documentation of the use of non-pharmacological interventions.

R56 resided in the memory care unit and had diagnoses that included Alzheimer ' s disease and dementia with behavioral disturbances.

R56 had a physician ' s order for Ativan 0.5 mg give 1 tablet by mouth every 4 hours as needed for anxiety and restlessness 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

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F 329	Continued From page 31 dementia with behaviors. The target behaviors were identified as confusion, looking for "dad", wanders in others rooms at times, may refuse medications and cares, may have verbal outbursts, statements of being afraid, anxiety, accusatory statements towards others, agitation, paranoia, tearfulness, physical abuse towards staff, delusion The interventions did not identify non-pharmacological interventions to try prior to using the as needed medication. Additional interventions listed in the care plan included : re-approach, 1:1, redirection, reassurance, validation PRN, allow resident time to express her feeling, frustrations, and sadness. In October R56 received 4 doses of as needed Ativan. Re view of the behavior documentation and nursing progress notes for October did not reveal the behavior or non-pharmacological interventions used prior to the as needed anti-anxiety medications. During an interview on 11/8/13 at 1:20 p.m. Clinical Manager (CM)-A stated staff should document non- pharmacological interventions on the progress notes.	F 329		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of	F 353	Resident R66's care plan was reviewed and updated to include interventions for staff to assist at mealtime with cues, prompts and assistance as needed. R37's care plan was reviewed and updated to include interventions for staff to assist at mealtime with cues and prompts to keep resident awake and to assist with eating if needed. R65's care plan was reviewed and updated to	

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F 353	Continued From page 32 personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This 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. Findings include: R66, R63, R65, R68, R37, R73 did not receive timely assistance during meals. The memory care unit was observed during the noon meals of 11/4/13 and 11/6/13. 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	F 353	include interventions for staff to put dentures in before meals and to provide cues, prompts and assistance with eating as needed. R63's care plan was reviewed and updated to include interventions for staff to provide cues, prompts, redirection and assistance as needed at mealtime. R38's care plan was reviewed and updated to include interventions for staff to assist at mealtime with cues, prompts and assistance as needed. R73's care plan was reviewed and updated to include interventions for staff to prepare resident for meals and provide redirection, prompts, cues and assistance as needed. In addition, the following interventions will be implemented on the 300 wing. 1. Meal trays will be placed in the food cart according to seating, not by diet. 2. A current seating chart will be maintained by the Nurse Manager for all meals. 3. The Nurse Manager or Charge Nurse for the unit will be responsible for calling for additional assistance at meal time if needed. 4. All staff will be re-educated on the correct procedures to be used during meal service, including: completing one table before starting another, creating a calm, quiet environment, washing hands before and after meals, keeping	

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F 353	Continued From page 33 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 p.m. which had been 28 minutes A Quarterly Minimum Data Set assessment dated 8/12/2013 identified R66 as severely cognitively impaired and required extensive 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 R63 to eat the meal when it was set in front of her or to use a fork to eat the cake. A quarterly MDS dated 9/6/2013 identified resident as severely cognitively impaired and required supervision and cueing after set up of meal. R65 had been observed to hold dentures in her hand during the meal and no staff attempted to encourage her to wear the lower denture. R65 was observed during the noon meal on 11/6/13 to	F 353	plates covered, and offering assistance to residents as needed. 5. A management staff person will be assigned to the 300 wing at meal time 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 to 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 an improvement in the overall results of 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 that staffing numbers are sufficient to provide safe care in accordance with the residents' plan of care including: The staffing coordinator and DON will develop a staffing binder for the nursing stations that will contain pertinent staffing information to assist with calling staff to fill open shifts. The staffing coordinator and DON created a list of options to be used if	

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F 353	Continued From page 34 use a fork to eat while clutching her dentures, eat with her fingers, take food out of her mouth and place it back on the plate. During the entire meal form 12:01 p.m. to 12:27 p.m. R65 had not been encouraged by staff to use her bottom denture to eat the meal nor had they encouraged her to use the fork to eat the foods provided. During an interview on 11/7/13 at 8:30 a.m. licensed practical nurse (LPN)-D stated staff was to encourage R65 to wear the dentures while eating. At breakfast that morning, R65 was again observed to have the denture in her hand. When asked by LPN-D to place the dentures in the mouth, R65 allowed LPN-D to do so and did not remove the dentures for the rest of the meal. R38 was not assisted during dining in a timely manner. On 11/4/13 at 12:25 p.m. R38 was provided the meal that had arrived on the unit 13 minutes earlier. The resident made no attempt to eat and no staff assisted the resident for 17 minutes. During that time the resident played with the clothing protector while other residents at the table ate. A quarterly minimum data set assessment dated 10/6/2013 identified resident as severely cognitively impaired and required limited assist of one staff for eating. R37 was not consistently cued nor assisted to eat during the noon meal on 11/6/13. The food plate sat in front of her for 21 minutes before staff sat to assist her to eat. A quarterly MDS dated 9/5/2013 identified the resident as moderately cognitively impaired and required supervision and cueing of one staff for eating R73 was not assisted in a timely manner during the noon meal on 11/4/13. R73 received her food 30 minutes after it arrived on the unit. During this	F 353	there is a call-in or for any staffing situation that requires additional assistance. This plan utilizes night shift staff, management staff, and non-nursing staff to assist with getting residents up and dressed, assisting with eating, etc. The DON will meet at least weekly with the staffing coordinator to review staffing needs. The DON will meet at least weekly with the Administrator to give updates on current staffing needs and/or problems. Staffing questions or concerns will be addressed at monthly Resident Council and Family Council. Nursing Staff was re-educated on the procedure and expectations for filling open shifts due to call-ins The Director of Nursing and Administrator and /or designee will monitor the corrective actions to ensure the effectiveness of these actions, including: Call Light Audits will be done weekly by staff and residents for 3 months to determine problems, patterns, perceptions, or specific areas in need of further action. Audit frequency will be reduced based on compliance and recommendations from the QA Committee.	

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F 353	Continued From page 35 30 minutes (12:12 to 12:45 p.m.) R73 was observed to propel the wheelchair about the dining room as the other residents ate. Residents R82 and R56 were noted to yell at R73 and then pound on the table for extended periods of time. On 11/4/2013 at 1:45 p.m. and again on 11/7/2013 at 9:00 a.m., LPN-D was interviewed regarding dining observations on 11/4/13 at noon. LPN-D stated it had been normal for some of the residents to wait to eat because of the short staffing. LPN-D said that they usually staffed one nursing assistant and one nurse during the day shift for 17 residents who needed quite a bit of assistance. The residents are assisted to eat as soon as they can get around to them. LPN-D said that the staff hadn ' t always been able to cue the residents to eat as they should have been nor had staff been able to monitor resident behaviors closely during dining because it was too busy during the dining meal to just get residents assisted to eat. LACK OF ASSISTANCE WITH GROOMING AND NAIL CARE: See F312 for example of R47, R56, R65 had not received finger nail care as they all three had long and dirty nails that had not been cleaned nor trimmed. FAMILY MEMBERS CONCERNS WITH LACK OF CARES FOR LOVED ONES ON THE MEMORY CARE UNIT: 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	F 353	Resident Interviews will be conducted by the DON or Administrator and/or designee weekly with at least 3 residents to determine current problems and perceptions. Audits will be done for 3 months and frequency will then be reduced based on audit results and recommendations from the QA Committee. Personal Hygiene Audits will be done on an ongoing basis. Audits will be done on at least 3 residents per week by staff from all departments. Audit results will be reviewed by the DON and/or Administrator and given to the appropriate Nurse Manager for follow up. Upon completion of reviews/audits, corrective actions, if applicable will be implemented immediately. Additional education will be provided as derived from the reviews. Failure to adhere to educated protocols will result in corrective counseling. The results of monitoring of the corrective actions (track, trend and analysis) will be reported to the facility QA Committee monthly for 6 months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan.	

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F-353	Continued From page 36 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: On 9/21/13 F-B indicated residents other than R47 had long dirty fingernails and that the nurse had said she would take care of it according to complaint written by F-B and given to the facility. On 9/29/13 F-B documented the director of nursing indicated there should be a minimum of 3 staff to meet the needs of the residents on the memory care unit but the DON said, "We need to pull them [nursing assistants] for other areas of the NH [nursing home]." F-B stated that at 12:00 noon on 9/29/13 she was in the unit with 16 residents waiting for their meals as the food tray cart had been in the dining room. There were two staff members helping another resident get to the table, so the food was not served to the residents until 12:30 p.m. On 9/30/13 F-B stated she had been with R47 all day from 10:15 a.m. to 4:30 p.m., and that R47 had not had their incontinence brief changed this entire time and when the staff did change the pad it had some bowel movement in the brief. F-B reported this incident to the DON at which time the DON said the long time employees were quitting and new staff are learning what to do. The licensed social worker (LSW) was interviewed on 11/8/13 at 1:50 p.m. LSW indicated she was aware of F-B ' s family	F-353	Facility DON and Administrator will be 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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concerns about inadequate cares being done for R47 and had a couple meetings with F-B to resolve the concerns. LSW stated she had had concerns voiced by several other families related to short staffing and cares not getting done for residents.

The clinical manager (CM)-B was interviewed on 11/8/13 at 11:00 a.m. She indicated the unit required a minimum staffing level of 2 nursing assistants on days and evening to meet the needs of the residents and provide for their safety. CM-B stated it had been "Awful" due to all the unmet cares that residents don ' t get and that nurses were not always available to help either. CM-B said that the residents who need two staff for bathing may not get a bath as there is only one staff on that day. Also the residents who need assistance to eat may have to wait long periods of time to be assisted. CM-B stated she felt that the number of falls have increased and some more serious because of the low staffing on the unit.

Employee-A (who requested not to be identified as they were afraid of being fired or retaliated against, so date and time of interview was not included) said that they had been told if the floor is short of staff they are to pull one from the Memory care unit shorting the memory care staffing and the staff on the memory care are told that they don ' t need to do bathing or showers for residents as it is low priority. E-A said this occurs 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

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F 353	Continued From page 38 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.	F 353		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain a sanitary environment to prevent the spread of food borne illness which included food handling practices, equipment cleaning, and sanitizing, drying and storage of dishes for resident food use. This had the potential to affect 57 of 57 residents in the facility that had been provided food prepared and distributed from the facility kitchen. Findings include: During initial tour of kitchen on 11/4/13, at 9:10 a.m., with dietary director observation revealed a fan attached to wall with a layer of dust build up and was blowing directly onto clean dishes. Also there had been a stand	F 371	Fans were both cleaned and a schedule was put in place to ensure they are cleaned monthly and as needed. The policy and procedure for sanitary kitchen conditions was reviewed and updated. All dietary staff were re-educated on proper food handling practices, equipment cleaning and proper dishwasher temperatures and procedures if temperatures are not met as noted in the deficiencies on 11/13/13. The Dietary Director will do audits 2 times a week x 1 month on proper sanitary procedures. If compliance is met, audits will be reduced to 1x per week for 3 months or per recommendation of the QA Committee. Upon completion of reviews/audits, corrective actions, if applicable, will be completed immediately. Additional education will be provided as derived from the audits. Failure to adhere to educated protocols will result in corrective counseling.	

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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 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.	F 371	The results of monitoring of the corrective actions (track, trend and analysis) will be reported to the QA Committee. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan. Facility Dietary Director will be 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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F 371	Continued From page 40 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 when serving food. During the taking of food temperatures on 11/7/13, at 11:05 a.m., cook (C)-A had been holding utensils in hands and held utensils up against uniform/apron 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 door handle to open door of closet, grabbed a wipe with same pair of gloves and proceeded to use the wipe to clean thermometer between checking different foods temperatures. While taking the food temperatures in steam table containers cook-A had been observed leaning over utensils and touching utensils with apron. On 11/7/13, at 11:19 a.m., CH-B had been observed to grab thermometer out of pencil holder which had just been used to check food temperatures from the steam table by C-A and placed the un-cleaned thermometer into pudding to check temperature . CH-C verified she had not cleaned the thermometer prior to putting in the pudding that was to be served to the resident. During meal service observation on 11/7/13, at 11:29 a.m., dietary director was observed picking up lettuce and tomatoes out of containers with soiled gloved hands and placing them on a plate with the same pair of gloves on that had touched handles of a drawer and refrigerator. During interview on 11/7/13, at 11; 46 a.m.,	F 371		

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F 371	Continued From page 41 dietary director verified they had grabbed lettuce and tomatoes out of food containers with same pair of soiled gloves that had touched handle of drawer and refrigerator with. During interview on 11/7/13, at 1:55 p.m., dietary director stated she expected staff to not touch utensils with uniform, should wash thermometer before use and not store thermometer with dirty items and expected gloves to be changed when soiled. Document review of facility Bare Hand Contact with Food and Use of Plastic Gloves dated 2010, read " Procedure: 6. Remember gloves are just like hands. They get soiled. Anytime a contaminated surface is touched, the gloves must be changed."	F 371		
F 373 SS=D	483.35(h) FEEDING ASST - TRAINING/SUPERVISION/RESIDENT A facility may use a paid feeding assistant, as defined in §488.301 of this chapter, if the feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and the use of feeding assistants is consistent with State law. A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). In an emergency, a feeding assistant must call a supervisory nurse for help on the resident call system. A facility must ensure that a feeding assistant feeds only residents who have no complicated feeding problems.	F 373	Residents R5, R7, and R80 have been reassessed by the Nurse Managers to determine if they are appropriate for receiving eating assistance from a PFA, and their care plans were reviewed and revised. All residents currently being fed by PFA's were reassessed for appropriateness by the Nurse Managers and care plans updated accordingly. Nurse Managers and the Dietary Manager will be responsible for completing assessments and determining appropriateness for residents to be assisted by a PFA. The Director of Nursing, Nurse Managers and Dietary Manager will	

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F 373	Continued From page 42 Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings. The facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care. NOTE: One of the specific features of the regulatory requirement for this tag is that paid feeding assistants must complete a training program with the following minimum content as specified at §483.160: o A State-approved training course for paid feeding assistants must include, at a minimum, 8 hours of training in the following: Feeding techniques. Assistance with feeding and hydration. Communication and interpersonal skills. Appropriate responses to resident behavior. Safety and emergency procedures, including the Heimlich maneuver. Infection control. Resident rights. Recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting those changes to the supervisory nurse. A facility must maintain a record of all individuals used by the facility as feeding assistants, who have successfully completed the training course for paid feeding assistants. This REQUIREMENT is not met as evidenced by:	F 373	implement corrective actions for all residents potentially affected by this practice including: A written procedure which includes the procedure to be used for new admissions; the procedure used to clinically assess residents and determine appropriateness for a PFA to assist; and the method used for identifying which residents can and cannot be assisted by a Feeding Assistant. Residents being assisted by a Feeding Assistant will be reviewed at weekly IDT meetings and with any significant change in condition. Nursing and dietary staff were educated on 11/27/13 on the revised policy and procedure for Paid Feeding Assistants. Random audits will be done weekly for 3 months by DON and/or Administrator to ensure compliance with weekly IDT reviews and changes	

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F 373	Continued From page 43 Based on observation, interview and document review, the facility failed to ensure 3 of 3 residents (R5, R7, and R80) reviewed for assistance with eating, were comprehensively assessed to be safely fed by a paid feeding assistant (PFA) (non-nursing trained person used to assist residents with eating). Findings include: R5, R7 and R80 were assisted by PFAs to eat however, R5, R7 and R80 had a history of having swallowing difficulties, and/or aspiration pneumonia and would not have qualified to have been safely assisted to eat using a PFA as the PFA lacks the training and skill to assist residents with swallowing difficulties safely. R5 had diagnoses that included dysphagia (difficulty swallowing) and dementia. Review of the quarterly Minimum Data Set (MDS) dated 10/14/13; identified R5 had severe cognitive impairment, required assistance with eating, had no swallowing difficulties, and received mechanically altered diet. R5's current physician orders dated 9/3/13 included mechanical soft texture diet with thin liquids. R5's care plan dated 10/28/13, identified the resident had received a mechanically altered diet, required assist at meals with eating, and had chewing and swallowing difficulties. The plan of care did not identify if the resident was safe to be fed by a PFA. The recommendation of the interdisciplinary team (IDT) allowed PFAs to assist R5 to eat even though R5 had documented swallowing problems.	F 373	in condition and appropriateness of residents currently being assisted with eating by feeding assistants. A review of the audit results by the Medical Director and QA Committee will 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 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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R7 had diagnoses that included dementia and esophageal reflux and had a history of pneumonitis due to inhalation of food or vomitus.

Review of the annual MDS dated 10/3/13; identified R7 had severe cognitive impairment, required assistance with eating, had no swallowing difficulties, and was on a mechanically altered diet. The current physician order dated 9/6/13 identified a mechanical soft texture die.

R7's care plan dated 9/24/13 identified swallowing difficulties, aspiration pneumonia, malnutrition and dehydration. The care plan intervention included assist to eat if resident unable, provide mechanically altered diet. The care plan did not identify if the resident was safe to be fed by a PFA. The recommendation of the interdisciplinary team (IDT) allowed PFAs to assist R7 to eat even though R7 had documented swallowing problems and aspiration pneumonia.

R80's diagnoses included end stage dementia, nausea, and esophageal reflux.

The quarterly MDS dated 10/09/13 identified R80 had severe cognitive impairment, required extensive assistance with eating, had no swallowing difficulties, and was on a mechanically altered diet. Current physician orders dated 9/11/13 included mechanical soft diet and nectar thick liquids.

R80's care plan dated 9/20/13, identified the resident had been unable to feed self and required assist with eating and drinking at meal time and between meal time. The care plan did not identify if the resident was safe to be fed by a PFA. The recommendation of the interdisciplinary

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team (IDT) allowed PFAs to assist R80 to eat even though R80 had documented swallowing problems.

On 11/4/13 at 12:12 p.m., the hospice aide was observed in the dining room feeding R80: R80 exhibited no swallowing or eating difficulties.

During interview on 11/05/13, at 4:00 p.m. director of nursing (DON) reported PFA assessment is completed by the registered dietitian (RD) and certified dietary manager (CDM.) The DON stated MDS questions, resident diagnoses, and speech therapy recommendations had been used to determine if a resident could be fed by PFA and was documented on the comments section on the MDS.

During interview on 11/6/13, at 1:50 p.m. the DON verified R5, R7, and R80 had been fed by PFA. DON stated the facility IDT had determined if residents had been safe to be fed by a PFA based on the RD, CDM and registered nurse (RN) assessment. The DON further stated a summary note would have been entered in the medical record to reflect the IDT decision. The DON verified residents with dysphagia diagnosis and history of aspiration should not have been fed by PFA. The DON further verified no comprehensive IDT assessment had been found to determine if R5, R7, and R80 could have been safely fed by PFA.

Review of the facility policy Feeding Assistance dated 2006, read, "A feeding assistant feeds only those residents who have no complicated eating problems. Complicated eating problems include, but are not limited to, difficulty swallowing and recurrent lung aspirations." The policy further

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	indicated the facility would base resident selection on the resident's latest assessment, plan of care and the RN assessment of the resident's current condition.			
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure the consultant pharmacist identified irregularities and reported them to the director of nursing and physician for use of non-pharmacological interventions before the administration of PRN pain medications for 1 of 5 residents (R8) and failed to assess for sleep disturbance for 1 of 5 residents (R8) reviewed for unnecessary medications. Findings include: R8 received as needed (PRN) pain medications (Tylenol and oxycodone) without first attempting non-pharmacological measures. R8 received antidepressant medication (Trazodone) for insomnia without being assessed for sleep	F 428	Residents R56 and R8 were reassessed for use of non-pharmacological interventions prior to administration of PRN anti-anxiety or pain medications and care plans were updated. Resident R8 was reassessed for use of non-pharmacological interventions prior to giving PRN sleep medications and care plan was updated. Pharmacy Consultant was updated on results of assessments and reason for deficiency related to F 428 Drug Regimen Review. The Consultant Pharmacist was re-educated on facility policy and procedure for use of non-pharmacological interventions prior to giving PRN meds for pain, anxiety or sleep. The Consultant Pharmacist was informed of the process to be used to prompt nursing staff to offer non-pharmacological interventions on the EMAR. A prompt will appear in the EMAR that will remind nurses to offer non-pharmacological interventions before giving PRN pain, sleep or anti-anxiety meds. There will be a list of 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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F 428	Continued From page 47 quality. R8 had been admitted on 2/18/13. R8 had diagnoses that included but not limited to dementia, osteoarthrosis, depressive disorder, chronic pain. The quarterly Minimum Data Set (MDS) dated 8/20/13, indicated R8 had no trouble sleeping, received scheduled pain medication, received PRN medication, received non-medication interventions for pain, frequent pain and pain intensity score of 10. R8's brief interview of mental status (BIMS) had been 9 out of 15 on the MDS and indicated moderate cognitive impairment. During review of R8's current physician orders dated 10/30/13, revealed an order for oxycodone 5milligrams (mg) every six hours PRN for breakthrough pain, Tylenol 650 mg every four hours PRN for pain and Trazodone 50 mg at bedtime for depression with insomnia. During review of R8's care plan review date 9/24/13, identified problem of impaired comfort and directed nurses to offer non-med interventions such as warm packs, cool packs, repositioning, distraction techniques PRN. At risk for interrupted sleep and directed staff to encourage activities and activeness during day, limit caffeine intake after three p.m. and provide quiet sleep environment. Diagnosis of insomnia and use of antidepressant medication for sleep had not been addressed on the care plan. During review of R8's medication administration record and progress notes of PRN medication documentation sheets the following had been noted from the dates of 10/4/13 through 10/31/13: R8 had had received a total of four doses of PRN	F 428	pharmacological interventions and documenting interventions and effectiveness. The Director of Nursing and/or designee will implement the same policy and procedure identified above to be used for all residents regarding the use of non-pharmacological interventions. All residents will be reviewed at care conferences or with significant changes for resident-specific non-pharmacological interventions. Medical Records or designee will be responsible for inputting non-pharmacological prompt in PCC for all new admissions. The Director of Nursing and/or designee will implement measures to ensure that this practice does not recur, including: Review and revision of the policy and procedure for Non-Pharmacological Interventions. A review of the revised policies by the Medical Director will be conducted to determine if policy meets current standards of practice. The Director of Nursing and/or designee will monitor the corrective actions to ensure the effectiveness of these actions by completing audits on at least 3 residents every week to ensure non-pharmacological interventions are being utilized and documented.	

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F 428	Continued From page 48 Tylenol with no documentation of non-pharmacological interventions attempted prior to administration and two doses of PRN oxycodone with no documentation of non-pharmacological interventions attempted prior to administration for one of two doses. Review from the dates of 11/1/13 through 11/7/13: R8 had received a total of two doses of PRN Tylenol with no documentation of non-pharmacological interventions attempted prior to administration for one of two doses and four doses of PRN oxycodone with no documentation of non-pharmacological interventions attempted for three of four doses. During interview on 11/7/13, at 8:38 a.m., registered nurse (RN)-C stated should monitor hours of sleep for diagnosis of insomnia and when a medication is started for sleep. RN-C verified no sleep monitoring had been done for R8. 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 tried 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	F 428	Upon completion of reviews/audits, corrective actions, if applicable will be completed immediately. Additional education will be provided as derived from the reviews. Failure to adhere to educated protocols will result in corrective counseling. The results of monitoring of the corrective actions (track, trend and analysis) will be reported to the facility QA Committee monthly for 6 months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan. Frequency of the audits will be reduced based on compliance and recommendations from the QA Committee. Facility DON will be responsible for maintaining compliance. The facility alleges that it will be in substantial compliance by 12/18/13.	12/18/13

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F 428	Continued From page 49 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 12/1/07, read " Procedure: 3. Facility should independently review each resident ' s medication regimen directly from the resident ' s medical chart and with Interdisciplinary Care Team members, resident or Repsonsible Party, as needed."	F 428		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of	F 431	The facility procedure for Disposal/Destruction of Controlled 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. The Nurse Managers will do weekly audits on disposal of transdermal medications for 3 months. Results will be given to the DON weekly to review. 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 corrective action.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS CARE CENTER	300 NORTH DOW STREET CANNON FALLS, MN 55009

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F-431	Continued From page 50 controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and documentation review, the facility failed to document destruction of fentanyl patches (a narcotic used for moderate to severe pain) for 3 of 3 medication rooms. This practice could encourage diversion of pain medications by staff, residents and/or visitors. Findings include: During medication storage tour on 11/8/13, at 8:40 a.m. licensed practical nurse (LPN)-C indicated the process for destruction of fentanyl patches had been to fold the patch up then placed into the sharps container (A sharps container is a term for a specially-made container that is predominantly used for medical needles and any other sharp medical instruments. It is also a secured enclosed system that deters removal of content easily or safely.) LPN-C confirmed fentanyl patch destruction had not included co-signatures of another nurse. During interview on 11/8/13, at 12:45 p.m. registered nurse (RN)-C verified the used fentanyl patches were placed in the sharps containers but indicated they had not had another nurse sign disposal of the patch. 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	F-431	The Medical Director and QA Committee will review the revised procedure and recommendations from the Committee will be implemented. The Director of Nursing or/designee will monitor the corrective actions to ensure the effectiveness of these actions, including compliance with controlled medication destruction/disposal. The results of monitoring of the corrective actions (track, trend and analysis) will be reported to the facility QA Committee monthly for 6 months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan. If there is compliance with the procedure after 3 months, audits will be reduced per recommendation of the QA Committee. Facility Director of Nursing will be 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS CARE CENTER	300 NORTH DOW STREET CANNON FALLS, MN 55009

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 51 patch over and placed the used patch in the sharps container and ideally two staff would initial the destruction. The DON confirmed the expectation would be that two staff would cosign the disposal of the fentanyl patch. The DON verified the fentanyl patch was a narcotic but identified not sure if that process was being performed. Requested a copy of fentanyl patch destruction policy however, none had been provided. During interview on 11/8/13, at 12:58 p.m. the facility consultant pharmacy verified " best practice " would have been for two nurses ' sign a form that the fentanyl patch was destroyed once removed from the resident.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to	F 441	The policy and procedure for cleaning the glucometer was reviewed and updated. It will be available at each nursing unit as a reference. Licensed nursing staff was educated on 11/27/13 on the policy and procedure for cleaning the glucometer, which included a return demonstration. All pool staff and new employees will be trained during orientation. The Director of Nursing and/or Nurse Managers will do audits 2 times a week x 1 month on cleaning of the glucometers. If compliance is met, audits will be reduced to 1x per week for 1 month, then monthly or per recommendation of the QA Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS CARE CENTER	300 NORTH DOW STREET CANNON FALLS, MN 55009

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 52 prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement procedures to prevent the possible spread of blood borne infections during blood glucose monitoring 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 contact with blood borne diseases. 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	F 441	Upon completion of reviews/audits, corrective actions, if applicable, will be completed immediately. Additional education will be provided as derived from the audits. Failure to adhere to educated protocols will result in corrective counseling. The results of monitoring of the corrective actions (track, trend and analysis) will be reported to the QA Committee for 6 months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan. Facility Director of Nursing will be 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS CARE CENTER	300 NORTH DOW STREET CANNON FALLS, MN 55009

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 53 was observed to remove the test strip which had a drop of blood on it and disposed it by having had rolled up in a glove. Upon returning to the medication cart, LPN-D used PDI Sani Hands wipes to wipe the glucometer but had not used any barrier but used bare hands to wipe the glucometer that had come in contact with the resident ' s blood. Once the glucometer was wiped, LPN-D immediately put the glucometer in the medication cart and had not allowed the two minute drying time to properly sanitize the glucometer. The Material Safety Data Sheet for PDI product identified the hand wipes as antimicrobial alcohol wipes. It has alcohol as the active ingredient. On 11/8/2013 at 4:00 p.m., the director of nursing was interviewed regarding products to use for cleansing of glucometer equipment. She verified the staff should be using the cleanser that required gloves and was the most stringent. The PDI cleanser (alcohol based) is not the one to be used. Some staff may not be educated well enough. Document review of the facility Cleaning and Disinfecting Blood Glucose Meters from Pathway Health Services Infection control manual 2010 was provided by the facility. 15. the Sani-cloth wipes have a 2- minute time for disinfecting HIV, HBV, HBC, diseases which are approved by the manufacture guidelines. 16. Sani-cloth wipes is an approved product on the CDC list for disinfecting equipment for blood borne pathogens. 17. gloves must be worn per MSDS sheet when using the Sani-Cloth wipes.	F 441		
F 465	483.70(h)	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING _____ B. WING _____	11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS CARE CENTER	300 NORTH DOW STREET CANNON FALLS, MN 55009

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465 SS=C	Continued From page 54 SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility had not maintained a sanitary environment in the kitchen where food was stored, cooked and served to 57 of 57 residents in the facility. Findings include: During initial tour of kitchen on 11/4/13, at 9:10 a.m., with dietary director, observation revealed the wall in the kitchen located behind the ovens had dust build up, grease spots and one of the ovens had a visible layer of food build up. Dietary director stated the ovens get cleaned once a month and between this cleaning if there are food spills they should be cleaned immediately. During interview on 11/7/13, at 11:22 a.m., dietary director stated she had no policy regarding the general cleaning schedule of kitchen environment which includes appliances, walls, etc.	F 465	The wall behind the oven the oven was cleaned. A policy was put into place including a general cleaning schedule of the kitchen environment. All dietary staff was re-educated on proper cleaning procedures including dust build up, grease spots and food build up as noted in the deficiencies on 11/13/13. The Dietary Director will do audit for cleanliness 2 times a week x1 month. If compliance is met, audits will be reduced to 1x per week for 5 months. Upon completion of reviews/audits, corrective actions, if applicable, will be completed immediately. Additional education will be provided as derived from the audits. Failure to adhere to educated protocols will result in corrective counseling. The results of monitoring of the corrective actions (track, trend and analysis) will be reported to the QA Committee for 6 months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan. Facility Dietary Director will be 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

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

F5304023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS CARE CENTER	300 NORTH DOW STREET CANNON FALLS, MN 55009

(X4) ID 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	K 000		

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE 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

DC: 12-16-13

EXIT: 11-6-13

POCok
1-14-14

RECEIVED
JAN - 9 2014
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 1-9-14

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS CARE CENTER	300 NORTH DOW STREET CANNON FALLS, MN 55009

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1	K 000		

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

This facility will be surveyed as two separate buildings. Angels Care Center is a 1-story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1977 and was determined to be of Type II(111) construction. In 1982, addition was constructed to the West Wing that was determined to be of Type II(111) construction. In 1985, another addition was added to the South Wing and was determined to be Type II (111).

The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification.

The facility has a capacity of 89 beds and had a census of 59 at the time of the survey.

The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:

K 067	NFPA 101 LIFE SAFETY CODE STANDARD	K 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS CARE CENTER	300 NORTH DOW STREET CANNON FALLS, MN 55009

(X4) ID 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 067 SS=F	Continued From page 2 Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This Standard is not met as evidenced by: Based on documentation review and staff interview, that the facility's general ventilating and air conditioning system (HVAC) was not maintained in accordance with the LSC, Section 19.5.2.1 and NFPA 90A, Section 3-4.7. A noncompliant HVAC system could affect all 59 residents. Findings include: On facility tour between 12:45 PM and 2:45 PM on 11/05/2013, documentation review of the fire damper testing log for the past 4 years revealed, all of the fire/smoke dampers have not been tested with-in the last 4 years. Last documented test was on 9/9/2009. This deficient practice was confirmed by the Facility Maintenance Director (DR) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 067	The facility had the fire/smoke dampers tested by Cannon Fire and Safety. The work was completed on 1/8/14. Ongoing compliance will be ensured by having the dampers added to our fire check log that is reviewed monthly. Facility maintenance director and executive director will be responsible for ensuring compliance.	

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 COMPLETED YES** ☐ **NO** ■

LOCATION: Angels Care Center

STREET ADDRESS: 300 Dow Street North **CITY:** Cannon Falls **STATE:** MN **ZIP:** 55009

WORK REQUESTED BY: Don Rapp **PH:** 263-4658 **EMAIL:** _____

WORK PERFORMED: Check the operation of the fire dampers per State Fire Marshal notice- Continued tracking 300 wing damper power supply and control circuit (which is branched to three different loads). Verified circuit loads to the damper control circuit, magnetic door holder circuit and magnetic door lock circuit.

Since the 300 wing damper control circuit is not a standard set-up, circuit function from HVAC unit conditions should be verified by your HVAC contractor.

Will return to complete work.

10:00- 1:15: 4 1/4 hours

PARTS: _____

TECHNICAN SIGNATURE

CUSTOMER SIGNATURE

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 **CUSTOMER PO#** _____ **JOB COMPLETED YES** ☐ **NO** ■

LOCATION: Angels Care Center

STREET ADDRESS: 300 Dow Street **CITY:** Cannon Falls **STATE:** MN **ZIP:** 55009

WORK REQUESTED BY: Don Rapp **PH:** 263-4658 **EMAIL:** _____

WORK PERFORMED: Check the operation of the fire dampers per State Fire Marshal notice- Checked 300 wing dampers for operation. Found several issues: Dampers are not connected to the fire alarm system, the circuit powering the dampers is not fused properly and is also powering the magnetic door holders and the electric door lock in the 300 wing, one damper is wedged open and communication cables are ran through one of the dampers, found many open junction boxes and improper circuit splices (fire alarm, damper control, electric door lock, and magnetic door holder circuits). Verified operation of all dampers by removing power at each damper. One damper is defective.

Began tracking damper control circuit through junction boxes and HVAC relays to verify relay contacts are closed to allow dampers to function properly.

Will return to complete work.

8:15am- 11:15am: 3 hours

PARTS: _____

TECHNICAN SIGNATURE

CUSTOMER SIGNATURE

12/27/13
DATE

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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 **CUSTOMER PO#** _____ **JOB COMPLETED YES** ☐ **NO** ■

LOCATION: Angels Care Center

STREET ADDRESS: 300 Dow Street North **CITY:** Cannon Falls **STATE:** MN **ZIP:** 55009

WORK REQUESTED BY: Don Rapp **PH:** 263-4658 **EMAIL:** _____

WORK PERFORMED: Check the operation of the fire dampers per Stat Fire Marshal notice- Checked operation of 100, 200, and 400 wing dampers. All damper close when power is removed at the damper. Verified circuit integrity of all damper circuits to control relays to fire alarm system. Manually triggered control relays and all dampers closed. Discovered that the programming of the fire alarm system had been altered and dampers would not shut when the fire alarm system was in alarm state. Reprogrammed fire alarm system for proper damper relay controls for the 100, 200, and 400 wings- all dampers function properly.

Will return to work on the 300 wing dampers.

8:30-11:45 & 12:30- 3:45: 6 1/2 hours

PARTS: _____

TECHNICAN SIGNATURE

CUSTOMER SIGNATURE

12/26/13
DATE

THIS IS NOT AN INVOICE

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING **02 - 2007 CHAPEL ADDITION** B. WING _____	**11/05/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS CARE CENTER	**300 NORTH DOW STREET CANNON FALLS, MN 55009**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. 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.	K 000		

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

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00758	A. BUILDING: _____ B. WING _____	11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS CARE CENTER	300 NORTH DOW STREET CANNON FALLS, MN 55009

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On November 4, 5, 6, 7 and 8, 2013, surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date on the bottom of the first page in the line marked with "Laboratory Direcor's or Provider/Supplier Representattive's signature",	2 000	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.	

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2 000	Continued From page 1 make a copy of these orders and return the original to the address below: Minnesota Department of Health 18 Wood Lake Drive SE, Rochester, MN 55904. c/o Gary Nederhoff, Unit Supervisor 507-206-2731 Investigation/s of complaint H5304018 had been completed and had been substantiated with findings issued at State Licensing Order/s MN Rule 4658.0525 subp. 6B, MN Rule 4658.0501 subp. 1 and MN State Statutes 144.651 subd. 5.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide eating	2 565		

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2 565	Continued From page 2	2 565		

assistance as assessed and care planned for 1 of 3 residents (R21) reviewed for nutritional services.

Findings include: R21 had not been assisted with meals or snacks according to R21's plan of care.

R21 had been admitted on 8/22/13 with diagnoses that included but not limited to diabetes, protein-calorie malnutrition. R21 ' s admission Minimum Data Set (MDS) dated 8/29/13, indicated R21 had a brief interview for mental status (BIMS) score of five, which is severe cognitive impairment.

R21's care plan revision dated 11/1/13, indicated: nutrition alteration per cognitive changes, need for consistency altered meats, one assist with meals and interventions: diet per physician orders, eating one assist to eat all meals.

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, carbohydrate 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 the hall/lobby area from dining room located by kitchen and R21 had been independently eating lunch. Dietary staff approached R21 once and asked R21 if doing ok and R21 had replied " Yeah. " 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

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2 565	Continued From page 3 Tater Tot Hotdish, bites out of cake, and drank approximately three quarters of juice. No staff person had sat with R21 during entire meal to assist or cue R21 to complete the meal. During observation on 11/7/13, at 7:19 a.m., R21 had been sitting in dining room located across hall/lobby area from dining room located by kitchen independently eating breakfast. R21 had an eight ounce glass of juice, cereal bowl of malt-o-meal. R21 had stated at 7:29 a.m., I have to go to the bathroom and left dining room. R21 had consumed approximately three quarters of 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.	2 565		

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2 565	Continued From page 4 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 more assistance lately, had not been 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 meals. 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." 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 CAN [NA]. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could monitor meal service to determine and establish staffing needs. The director of nursing or designee could monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 565		

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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. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to update the care plan interventions related to falls for 1 of 3 residents (R56) reviewed for falls and failed to develop care plan interventions to address non-English speaking communication needs for 1 of 1 resident (R78) who only understood Spanish. Findings include: R56 had frequent falls and the facility had assessed that family (F)-A had been assisting R56 when the falls had occurred. However, the intervention to remind F-A to seek staff help if R56 needed to be transferred had not been included in the care plan for staff to be aware of this concern and intervention. On 11/6/13 at 8:00 a.m. R56's F-A had been observed to push R56 in the wheelchair while visit. R56 had diagnoses that included dementia,	2 570		

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2 570	Continued From page 6	2 570		

history of rib fracture, femur fractures, and vertebra fractures.

Incident in notes dated 9/25/13 read that R56 was found on floor on knees holding the bed. Predisposing factors included gait imbalance and impaired memory. No injury was noted. Incident in notes dated 10/13/13 R56 was found on floor next to the bed. R56 complained of right hip pain, but had no difficulty with range of motion.

The quarterly Minimum Data Set dated 10/22/13 indicated R56 was severally cognitively impaired and required extensive assistance with transfers, bed mobility and did not walk. Fall Risk Assessment dated 7/19/13 indicated R56 was at moderate risk for falls related to cognitive deficits, poor decision making, urinary incontinence, a history of pain with weight bearing, medications, and a history of agitated behaviors.

R56 ' s care plan undated identified a problem of impaired mobility with risk for falls related to dementia, hypertension, osteoarthritis, self-transfers as evidenced by a history of falls, decreased safety awareness, need assist with mobility. The care plan lacked an intervention or reminding the spouse not to help the resident transfer.

Nursing Assistant (NA)-B was interviewed on 11/8/13 at 9:49 a.m. NA-B stated she thought that sometimes F-A had been trying to transfer R56. Staff then tries to intervene if they see this happen. NA-B stated she has never seen R56 attempt to transfer self.

Clinical Manager (CM)-B was interviewed at 11:00 a.m. on 11/8/13. CM-B stated R56 had

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2 570	Continued From page 7	2 570		

been falling a lot, but now that F-A had not been transferring R56 alone as much, R56 was not falling. CM-B stated F-A liked to help C56 as much as possible and needed reminders by staff not to help transfer R56 alone as R56 falls when this occurs.

During an interview on 11/8/13 at 12:20 p.m. the director of nursing verified R56 ' s care plan did not include an intervention related to reminding F-A not to transfer R56 and get help if R56 needs to be moved or transferred.

R78 had been assessed to not understand English as a spoken language or as a written language as they only understood Spanish.

R78 had been admitted on 6/4/13. R78 had diagnoses that included but not limited to anoxic brain damage, aphasia. R78's significant change Minimal Data Set (MDS) dated 10/15/13 identified preferred language Spanish, no speech, rarely/never understood. R78's care area assessment (CAA) worksheet dated 10/21/13, identified nature of the problem/condition: essentially non-verbal related to anoxic brain damage, aphasia, primary language Spanish and characteristics of the communication impairment.

R78's care plan review date 10/22/13, identified vulnerable adult as depends on staff for all cares and is unable to communicate with only intervention of use interpreter. R78's care plan had no other interventions to promote communication needs.

R78's therapeutic recreation summary dated 10/15/13 identified primary language Spanish.

During observation on 11/4/13, at 1:09 p.m.,

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2 570	Continued From page 8	2 570		

activities-A had been in R78's room talking to R78 in English and had stated to surveyor R78 does not speak English, R78 looks at you but does not talk. She had stated R78's language was Spanish. The television had been on in R78's room and had been on the Spanish channel for R78 to watch.

During interview on 11/7/13, at 8:44 a.m., social service person stated R78 does not speak English, is non-verbal and speech therapy had not worked with R78 regarding language barrier and communication. Social service stated she had talked about interpreter with family, not sure what they want to do.

During interview on 11/7/13, at 12:55 p.m., nursing assistant (NA)-E stated I do not speak Spanish. NA-E stated I talk to R78 in English and use hand gestures. NA-E stated staff development gave a sheet with some simple English words converted to Spanish for us to use. However, this was not used routinely and not part of the care plan.

During interview on 11/7/13, at 2:00 p.m., speech therapist stated she provided swallow therapy only for R78. Speech therapist stated she had tried some communication in Spanish with R78 and there was no response. Speech therapist verified there is no documentation in therapy notes regarding communication and had not given anything to staff to use for communication. Speech therapist verified R78 understands and 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

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2 570	Continued From page 9 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.	2 570		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements 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. Findings include: R66, R63, R65, R68, R37, R73 did not receive timely assistance during meals. The memory care unit was observed during the noon meals of 11/4/13 and 11/6/13.	2 800		

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2 800	Continued From page 10 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 p.m. which had been 28 minutes A Quarterly Minimum Data Set assessment dated 8/12/2013 identified R66 as severely cognitively impaired and required extensive 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	2 800		

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2 800	Continued From page 11 R63 to eat the meal when it was set in front of her or to use a fork to eat the cake. A quarterly MDS dated 9/6/2013 identified resident as severely cognitively impaired and required supervision and cueing after set up of meal. R65 had been observed to hold dentures in her hand during the meal and no staff attempted to encourage her to wear the lower denture. R65 was observed during the noon meal on 11/6/13 to use a fork to eat while clutching her dentures, eat with her fingers, take food out of her mouth and place it back on the plate. During the entire meal form 12:01 p.m. to 12:27 p.m. R65 had not been encouraged by staff to use her bottom denture to eat the meal nor had they encouraged her to use the fork to eat the foods provided. During an interview on 11/7/13 at 8:30 a.m. licensed practical nurse (LPN)-D stated staff was to encourage R65 to wear the dentures while eating. At breakfast that morning, R65 was again observed to have the denture in her hand. When asked by LPN-D to place the dentures in the mouth, R65 allowed LPN-D to do so and did not remove the dentures for the rest of the meal. R38 was not assisted during dining in a timely manner. On 11/4/13 at 12:25 p.m. R38 was provided the meal that had arrived on the unit 13 minutes earlier. The resident made no attempt to eat and no staff assisted the resident for 17 minutes. During that time the resident played with the clothing protector while other residents at the table ate. A quarterly minimum data set assessment dated 10/6/2013 identified resident as severely cognitively impaired and required limited assist of one staff for eating. R37 was not consistently cued nor assisted to eat during the noon meal on 11/6/13. The food plate	2 800		

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2 800	Continued From page 12 sat in front of her for 21 minutes before staff sat to assist her to eat. A quarterly MDS dated 9/5/2013 identified the resident as moderately cognitively impaired and required supervision and cueing of one staff for eating R73 was not assisted in a timely manner during the noon meal on 11/4/13. R73 received her food 30 minutes after it arrived on the unit. During this 30 minutes (12:12 to 12:45 p.m.) R73 was observed to propel the wheelchair about the dining room as the other residents ate. Residents R82 and R56 were noted to yell at R73 and then pound on the table for extended periods of time. On 11/4/2013 at 1:45 p.m. and again on 11/7/2013 at 9:00 a.m., LPN-D was interviewed regarding dining observations on 11/4/13 at noon. LPN-D stated it had been normal for some of the residents to wait to eat because of the short staffing. LPN-D said that they usually staffed one nursing assistant and one nurse during the day shift for 17 residents who needed quite a bit of assistance. The residents are assisted to eat as soon as they can get around to them. LPN-D said that the staff had ' t always been able to cue the residents to eat as they should have been nor had staff been able to monitor resident behaviors closely during dining because it was too busy during the dining meal to just get residents assisted to eat. LACK OF ASSISTANCE WITH GROOMING AND NAIL CARE: See F312 for example of R47, R56, R65 had not received finger nail care as they all three had long and dirty nails that had not been cleaned nor trimmed.	2 800		

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2 800	Continued From page 13 FAMILY MEMBERS CONCERNS WITH LACK OF CARES FOR LOVED ONES ON THE MEMORY CARE UNIT: 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: On 9/21/13 F-B indicated residents other than R47 had long dirty fingernails and that the nurse had said she would take care of it according to complaint written by F-B and given to the facility. On 9/29/13 F-B documented the director of nursing indicated there should be a minimum of 3 staff to meet the needs of the residents on the memory care unit but the DON said, "We need to pull them [nursing assistants] for other areas of the NH [nursing home]." F-B stated that at 12:00 noon on 9/29/13 she was in the unit with 16 residents waiting for their meals as the food tray cart had been in the dining room. There were two staff members helping another resident get to the table, so the food was not served to the residents until 12:30 p.m. On 9/30/13 F-B stated she had been with R47 all day from 10:15 a.m. to 4:30 p.m., and that R47 had not had their incontinence brief changed this entire time and when the staff did change the pad it had some bowel movement in the brief. F-B reported this incident to the DON	2 800		

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2 800	Continued From page 14 at which time the DON said the long time employees were quitting and new staff are learning what to do. The licensed social worker (LSW) was interviewed on 11/8/13 at 1:50 p.m. LSW indicated she was aware of F-B ' s family concerns about inadequate cares being done for R47 and had a couple meetings with F-B to resolve the concerns. LSW stated she had had concerns voiced by several other families related to short staffing and cares not getting done for residents. The clinical manager (CM)-B was interviewed on 11/8/13 at 11:00 a.m. She indicated the unit required a minimum staffing level of 2 nursing assistants on days and evening to meet the needs of the residents and provide for their safety. CM-B stated it had been "Awful" due to all the unmet cares that residents don ' t get and that nurses were not always available to help either. CM-B said that the residents who need two staff for bathing may not get a bath as there is only one staff on that day. Also the residents who need assistance to eat may have to wait long periods of time to be assisted. CM-B stated she felt that the number of falls have increased and some more serious because of the low staffing on the unit. Employee-A (who requested not to be identified as they were afraid of being fired or retaliated against, so date and time of interview was not included) said that they had been told if the floor is short of staff they are to pull one from the Memory care unit shorting the memory care staffing and the staff on the memory care are told that they don ' t need to do bathing or showers for residents as it is low priority. E-A said this occurs	2 800		

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2 800	Continued From page 15 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 staffing levels and monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 800		
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: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion.	2 895		

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2 895	Continued From page 16 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide range of motion services (ROM) as recommended by the physical therapist for 1 of 3 residents (R52) reviewed for range of motion services. Findings include: R52 did not receive the range of motion services or use the hand/finger splint as recommended by the physical therapist. R52 was observed on 11/4/13 at 2; 45 p.m. lying in bed and on 11/05/2013 at 02:47 p.m. R47 was observed sitting in the wheelchair. When asked to open right hand, R57 was unable to straighten out fingers on right hand. No splint had been present. During observations on 11/7/13 from 8:30 a.m. to 9:00 a.m., R52 was observed during morning cares receiving assistance with personal hygiene and dressing. R52 could move all upper extremity joints to some extent and was able to transfer with the E-Stand lift. R52 did not utilize a right hand splint and no range of motion was provided or offered during this time. During an interview on 11/7/13 at 11:12 a.m. R52 stated no range of motion to contracted right hand had been done by staff. R52 stated that staff had done range of motion to leg as R52 moved right leg back and forth. During an interview on 11/7/13 at 11:15 a.m. nursing assistant (NA)-A stated that the contracted hand should be washed with morning cares, but no range of motion is done because	2 895		

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2 895	Continued From page 17 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. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review transcription of physical therapist recommendations, evaluate staff provision of range of motion services, and monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 895		

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2 920	Continued From page 18	2 920		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs 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.) Findings include: R47 lacked assistance for trimming and cleaning 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	2 920		

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2 920	Continued From page 19	2 920		

hygiene. The care area assessment (CAA) dated 6/19/13 indicated R47 lived on the memory unit and had diagnoses that included dementia, anxiety, depression, osteoarthritis and history of hip fracture. The CAA noted R47 needed assistance with ADLs. The care plan dated 10/3/13 noted an intervention of " nail care after bathing as needed."
The director of nursing (DON) was interviewed on 11/8/13 at 2:50 p.m. DON stated she was aware of F-A ' s concerns which were reported this last summer. DON stated she remembered concerns were about R47 ' s finger nails. DON stated they had been disappointed that F-A had the same concern a couple months later. R47 had been transferred to another home after F-A had complained of R47 not getting adequate cares.

R56 lacked trimming and cleaning of finger nails.

R56 was observed on 11/4/13 at 12:11 p.m. R56 was noted to have long and dark colored fingers nails on both hands. On 11/6/13 at 8:00 a.m. R56 was observed in the wheelchair. R56 ' s fingers nails were observed to remain long and soiled under nails on both hands.

The quarterly MDS dated 10/22/13 was reviewed. The MDS indicated R56 was severely cognitively impaired and required extensive assistance of one for personal grooming and bathing.

The care plan provided 11/6/13 identified a problem of self-care deficit in dressing, bathing, and grooming related to dementia and 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

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2 920	Continued From page 20	2 920		

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 looking finger nails. On 11/7/2013 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 while eating breakfast eating with long dirty fingernails.

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 assistance to complete ADL's. Interventions: Bathing: 1 assist to complete. Encourage independence with upper body. Nail care after bathing as needed. Report any changes to the nurse. PERSONAL HYGIENE: 1 assist to complete, cue/encourage independence with

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2 920	Continued From page 21 upper body. R65's MDS dated 10/11/2013 identified resident as severely cognitively impaired and required extensive assist of one staff for personal hygiene activities of daily living. On 11/7/2013 at 1:15 p.m., nurse aide (NA) - G stated they were to do resident nails on bath days which were weekly. On 11/8/2013 at 10:40 a.m., a clinical nurse manager (CNM)-B stated the staff should be checking finger nails every bath day and trim if needed. The policy entitled Nails Care of (Finger and Toe) dated 2006 noted the purpose as to provide cleanliness, prevent spread of infection, comfort, to prevent skin problems. The procedure did not include the frequency of nail care. The facility policies entitled Bath (partial) dated 2006 and Bath (bed) dated 2006, directed staff to "care of fingernails and toenails is part of the bath." R21 had not been assisted with meals or snacks according to R21's plan of care. R21 had been admitted on 8/22/13 with diagnoses that included but not limited to diabetes, protein-calorie malnutrition, and carcinoma of prostate. R21's admission Minimum Data Set (MDS) dated 8/29/13, indicated R21 had a brief interview for mental status (BIMS) score of five, severe cognitive impairment. R21's care plan revision dated 11/1/13, indicated focus: nutrition alteration per cognitive changes, need for consistency altered meats, one assist with meals and interventions: diet per physician orders, eating one assists to eat all meals.	2 920		

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2 920	Continued From page 22 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 quarters of juice. No staff person had sat with R21 during entire meal to assist R21. During observation on 11/7/13, at 7:19 a.m., R21 had been sitting in dining room located across hall/lobby area from dining room located by kitchen independently eating breakfast. R21 had an eight ounce glass of juice, cereal bowl of malt-o-meal. R21 had stated at 7:29 a.m., I have to go to the bathroom and left dining room. R21 had drunk approximately three quarters of 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 R21. 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	2 920		

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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 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, 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 cares provided to residents to determine	2 920		

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ANGELS CARE CENTER	300 NORTH DOW STREET CANNON FALLS, MN 55009

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2 920	Continued From page 24 resident/staffing needs, educate staff, and monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 920		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain a sanitary environment to prevent the spread of food borne illness which included food handling practices, equipment cleaning, and sanitizing, drying and storage of dishes for resident food use. This had the potential to affect 57 of 57 residents in the facility that had been provided food prepared and distributed from the facility kitchen. Findings include: During initial tour of kitchen on 11/4/13, at 9:10 a.m., with dietary director observation revealed a fan attached to wall with a layer of dust build up and was blowing directly onto clean dishes. Also there had been a stand 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.	21015		

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21015	Continued From page 25 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 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 when serving food.	21015		

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21015	Continued From page 26 During the taking of food temperatures on 11/7/13, at 11:05 a.m., cook (C)-A had been holding utensils in hands and held utensils up against uniform/apron 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 door handle to open door of closet, grabbed a wipe with same pair of gloves and proceeded to use the wipe to clean thermometer between checking different foods temperatures. While taking the food temperatures in steam table containers cook-A had been observed leaning over utensils and touching utensils with apron. On 11/7/13, at 11:19 a.m., CH-B had been observed to grab thermometer out of pencil holder which had just been used to check food temperatures from the steam table by C-A and placed the un-cleaned thermometer into pudding to check temperature . CH-C verified she had not cleaned the thermometer prior to putting in the pudding that was to be served to the resident. During meal service observation on 11/7/13, at 11:29 a.m., dietary director was observed picking up lettuce and tomatoes out of containers with soiled gloved hands and placing them on a plate with the same pair of gloves on that had touched handles of a drawer and refrigerator. During interview on 11/7/13, at 11; 46 a.m., dietary director verified they had grabbed lettuce and tomatoes out of food containers with same pair of soiled gloves that had touched handle of drawer and refrigerator with. During interview on 11/7/13, at 1:55 p.m., dietary director stated she expected staff to not touch utensils with uniform, should wash thermometer before use and not store thermometer with dirty items and expected gloves to be changed when	21015		

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21015	Continued From page 27 soiled. Document review of facility Bare Hand Contact with Food and Use of Plastic Gloves dated 2010, read " Procedure: 6. Remember gloves are just like hands. They get soiled. Anytime a contaminated surface is touched, the gloves must be changed." SUGGESTED METHOD OF CORRECTION: The administrator and dietary manager could educate staff related to dietary sanitation and monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21015		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement procedures to prevent the possible spread of blood borne infections during blood glucose monitoring 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 anti-microbial 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	21375		

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21375	Continued From page 28	21375		

glucometer and had been at risk to come in contact with blood borne diseases.

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 was observed to remove the test strip which had a drop of blood on it and disposed it by having had rolled up in a glove. Upon returning to the medication cart, LPN-D used PDI Sani Hands wipes to wipe the glucometer but had not used any barrier but used bare hands to wipe the glucometer that had come in contact with the resident ' s blood. Once the glucometer was wiped, LPN-D immediately put the glucometer in the medication cart and had not allowed the two minute drying time to properly sanitize the glucometer.

The Material Safety Data Sheet for PDI product identified the hand wipes as antimicrobial alcohol wipes. It has alcohol as the active ingredient.

On 11/8/2013 at 4:00 p.m., the director of nursing was interviewed regarding products to use for cleansing of glucometer equipment. She verified the staff should be using the cleanser that required gloves and was the most stringent. The PDI cleanser (alcohol based) is not the one to be used. Some staff may not be educated well enough.

Document review of the facility Cleaning and Disinfecting Blood Glucose Meters from Pathway Health Services Infection control manual 2010 was provided by the facility. 15. the Sani-cloth wipes have a 2- minute time for disinfecting HIV, HBV, HBC, diseases which are approved by the manufacture guidelines. 16. Sani-cloth wipes is an approved product on the CDC list for

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21375	Continued From page 29 disinfecting equipment for blood borne pathogens. 17. gloves must be worn per MSDS sheet when using the Sani-Cloth wipes. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could educate staff on the appropriate cleaning of multiple patient use equipment to prevent cross contamination and then monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 4 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced	21426		

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21426	Continued From page 30 by: Based on interview and document review the facility failed to complete a Tuberculosis (TB) risk assessment according to the current Centers for Disease Control (CDC) guidelines for preventing the transmission of Tuberculosis. Findings include: The facility lacked an updated Tuberculosis Risk Assessment Worksheet. The facility TB risk assessment had been completed September 2011 and had been hand written due 2016. The TB Risk Assessment information dated April 10, 2012, revealed the assessment should be reviewed and updated periodically. MDH recommends that medium-risk health care settings update their risk assessment worksheet yearly and low-risk health care settings update their worksheet every other year. During interview on 11/8/13, at 11:03 a.m. the director of nursing (DON) verified the TB risk assessment was completed in September 2011 and due 2016 according to the worksheet. The DON verified was not sure when a new TB risk assessment needed to be completed. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing would ensure the TB risk assessment would be completed according to the CDC recommendations. TIME PERIOD FOR CORRECTION: Ten (10) days.	21426		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review	21530		

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21530	Continued From page 31 A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee.	21530		

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21530	Continued From page 32 This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to ensure the consultant pharmacist identified irregularities and reported them to the director of nursing and physician for use of non-pharmacological interventions before the administration of PRN pain medications for 1 of 5 residents (R8) and failed to assess for sleep disturbance for 1 of 5 residents (R8) reviewed for unnecessary medications. Findings include: R8 received as needed (PRN) pain medications (Tylenol and oxycodone) without first attempting non-pharmacological measures. R8 received antidepressant medication (Trazodone) for insomnia without being assessed for sleep quality. R8 had been admitted on 2/18/13. R8 had diagnoses that included but not limited to dementia, osteoarthrosis, depressive disorder, chronic pain. The quarterly Minimum Data Set (MDS) dated 8/20/13, indicated R8 had no trouble sleeping, received scheduled pain medication, received PRN medication, received non-medication interventions for pain, frequent pain and pain intensity score of 10. R8's brief interview of mental status (BIMS) had been 9 out of 15 on the MDS and indicated moderate cognitive impairment. During review of R8's current physician orders dated 10/30/13, revealed an order for oxycodone 5 milligrams (mg) every six hours PRN for breakthrough pain, Tylenol 650 mg every four hours PRN for pain and Trazodone 50 mg at	21530		

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21530	Continued From page 33 bedtime for depression with insomnia. During review of R8's care plan review date 9/24/13, identified problem of impaired comfort and directed nurses to offer non-med interventions such as warm packs, cool packs, repositioning, distraction techniques PRN. At risk for interrupted sleep and directed staff to encourage activities and activeness during day, limit caffeine intake after three p.m. and provide quiet sleep environment. Diagnosis of insomnia and use of antidepressant medication for sleep had not been addressed on the care plan. During review of R8's medication administration record and progress notes of PRN medication documentation sheets the following had been noted from the dates of 10/4/13 through 10/31/13: R8 had had received a total of four doses of PRN Tylenol with no documentation of non-pharmacological interventions attempted prior to administration and two doses of PRN oxycodone with no documentation of non-pharmacological interventions attempted prior to administration for one of two doses. Review from the dates of 11/1/13 through 11/7/13: R8 had received a total of two doses of PRN Tylenol with no documentation of non-pharmacological interventions attempted prior to administration for one of two doses and four doses of PRN oxycodone with no documentation of non-pharmacological interventions attempted for three of four doses. During interview on 11/7/13, at 8:38 a.m., registered nurse (RN)-C stated should monitor hours of sleep for diagnosis of insomnia and when a medication is started for sleep. RN-C verified no sleep monitoring had been done for R8.	21530		

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21530	Continued From page 34 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 tried 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 12/1/07, read " Procedure: 3. Facility should independently review each resident ' s medication regimen directly from the 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 pharmacist could monitor the use of non-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.	21530		

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21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure use of non-pharmacological interventions had been attempted before the administration of as needed antianxiety medications and pain medications for 2 of 5 residents (R8, R56) and failed to assess for sleep disturbance for 1 of 5 residents (R8) reviewed for unnecessary medications. Findings include: R8 received as needed (PRN)	21535		

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pain medications (Tylenol and oxycodone) without first attempting non-pharmacological measures. R8 received antidepressant medication (Trazodone) for insomnia without being assessed for sleep quality.

R8 had been admitted on 2/18/13. R8 had diagnoses that included but not limited to dementia, osteoarthrosis, depressive disorder, chronic pain. The quarterly Minimum Data Set (MDS) dated 8/20/13, indicated R8 had no trouble sleeping, received scheduled pain medication, received PRN medication, received non-medication interventions for pain, frequent pain and pain intensity score of 10. R8's brief interview of mental status (BIMS) had been 9 out of 15 on the MDS and indicated moderate cognitive impairment.

During review of R8's current physician orders dated 10/30/13, revealed an order for oxycodone 5 milligrams (mg) every six hours PRN for breakthrough pain, Tylenol 650 mg every four hours PRN for pain and Trazodone 50 mg at bedtime for depression with insomnia.

During review of R8's care plan review date 9/24/13, identified problem of impaired comfort and directed nurses to offer non-medication (or non-pharmacological) interventions such as warm packs, cool packs, repositioning, distraction techniques PRN. At risk for interrupted sleep and directed staff to encourage activities and activeness during day, limit caffeine intake after three p.m. and provide quiet sleep environment. Diagnosis of insomnia and use of antidepressant medication for sleep had not been addressed on the care plan.

During review of R8's medication administration

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21535	Continued From page 37 record and progress notes of PRN medication documentation sheets the following had been noted from the dates of 10/4/13 through 10/31/13: R8 had had received a total of four doses of PRN Tylenol with no documentation of non-pharmacological interventions attempted prior to administration and two doses of PRN oxycodone with no documentation of non-pharmacological interventions attempted prior to administration for one of two doses. Review from the dates of 11/1/13 through 11/7/13: R8 had received a total of two doses of PRN Tylenol with no documentation of non-pharmacological interventions attempted prior to administration for one of two doses and four doses of PRN oxycodone with no documentation of non-pharmacological interventions attempted for three of four doses. During interview on 11/7/13, at 8:38 a.m., registered nurse (RN)-C stated should monitor hours of sleep for diagnosis of insomnia and when a medication is started for sleep. RN-C verified no sleep monitoring had been done for R8. 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 tried prior to administering PRN pain medication and to document the non-pharmacological interventions.	21535		

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ANGELS CARE CENTER	300 NORTH DOW STREET CANNON FALLS, MN 55009

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21535	Continued From page 38 Document review of facility PAIN EVALUATION AND MANAGEMENT dated 2010, read "POLICY It is the policy for Volunteers of America (VOA) that all residents have the right for appropriate pain assessment and pain management. All residents will be evaluated for indicators or a history of pain for the MDS 3.0 on admission, quarterly, with a significant change in status, and with new onset of potential pain or discomfort. Data will be collected through resident interviews, staff interviews and observations." Surveyor had requested from facility a policy for sleep, none had been provided. R56 received antianxiety medications as needed without documentation of the use of non-pharmacological interventions. R56 resided in the memory care unit and had diagnoses that included Alzheimer ' s disease and dementia with behavioral disturbances. R56 had a physician ' s order for Ativan 0.5 mg give 1 tablet by mouth every 4 hours as needed for anxiety and restlessness 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 dementia with behaviors. The target behaviors were identified as confusion, looking for "dad", wanders in others rooms at times, may refuse medications and cares, may have verbal	21535		

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21535	Continued From page 39 outbursts, statements of being afraid, anxiety, accusatory statements towards others, agitation, paranoia, tearfulness, physical abuse towards staff, delusion The interventions did not identify non-pharmacological interventions to try prior to using the as needed medication. Additional interventions listed in the care plan included : re-approach, 1:1, redirection, reassurance, validation PRN, allow resident time to express her feeling, frustrations, and sadness. In October R56 received 4 doses of as needed Ativan. Re view of the behavior documentation and nursing progress notes for October did not reveal the behavior or non-pharmacological interventions used prior to the as needed anti-anxiety medications. During an interview on 11/8/13 at 1:20 p.m. Clinical Manager (CM)-A stated staff should document non- pharmacological interventions on the progress notes. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could evaluate the use of non-pharmacological interventions used with as needed psychotropic and pain medications and monitor compliance with the use of these medications. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21535		
21630	MN Rule 4658.1350 Subp. 2 A.B. Disposition of Medications; Destruction Subp. 2. Destruction of medications. A. Unused portions of controlled substances remaining in the nursing home after death or	21630		

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21630	Continued From page 40 discharge of a resident for whom they were prescribed, or any controlled substance discontinued permanently must be destroyed in a manner recommended by the Board of Pharmacy or the consultant pharmacist. The board or the pharmacist must furnish the necessary instructions and forms, a copy of which must be kept on file in the nursing home for two years. B. Unused portions of other prescription drugs remaining in the nursing home after the death or discharge of the resident for whom they were prescribed or any prescriptions discontinued permanently, must be destroyed according to part 6800.6500, subpart 3, or must be returned to the pharmacy according to part 6800.2700, subpart 2. A notation of the destruction listing the date, quantity, name of medication, prescription number, signature of the person destroying the drugs, and signature of the witness to the destruction must be recorded on the clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview and documentation review, the facility failed to document destruction of fentanyl patches (a narcotic used for moderate to severe pain) for 3 of 3 medication rooms. This practice could encourage diversion of pain medications by staff, residents and/or visitors. Findings include: During medication storage tour on 11/8/13, at 8:40 a.m. licensed practical nurse (LPN)-C indicated the process for destruction of fentanyl patches had been to fold the patch up then placed into the sharps container (A sharps container is a term for a specially-made container that is predominantly used for medical needles and any other sharp medical instruments. It is	21630		

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21630	Continued From page 41 also a secured enclosed system that deters removal of content easily or safely.) LPN-C confirmed fentanyl patch destruction had not included co-signatures of another nurse. During interview on 11/8/13, at 12:45 p.m. registered nurse (RN)-C verified the used fentanyl patches were placed in the sharps containers but indicated they had not had another nurse sign disposal of the patch. 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 patch over and placed the used patch in the sharps container and ideally two staff would initial the destruction. The DON confirmed the expectation would be that two staff would cosign the disposal of the fentanyl patch. The DON verified the fentanyl patch was a narcotic but identified not sure if that process was being performed. Requested a copy of fentanyl patch destruction policy however; none had been provided. During interview on 11/8/13, at 12:58 p.m. the facility consultant pharmacy verified " best practice " would have been for two nurses ' sign a form that the fentanyl patch was destroyed once removed from the resident. SUGGESTED METHOD OF CORRECTION: The director of nursing and pharmacist could educate staff in the disposal of controlled medications and monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21630		

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21685	Continued From page 42	21685		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility had not maintained a sanitary environment in the kitchen where food was stored, cooked and served to 57 of 57 residents in the facility. Findings include: During initial tour of kitchen on 11/4/13, at 9:10 a.m., with dietary director, observation revealed the wall in the kitchen located behind the ovens had dust build up, grease spots and one of the ovens had a visible layer of food build up. Dietary director stated the ovens get cleaned once a month and between this cleaning if there are food spills they should be cleaned immediately. During interview on 11/7/13, at 11:22 a.m., dietary director stated she had no policy regarding the general cleaning schedule of kitchen environment which includes appliances, walls, etc. SUGGESTED METHOD OF CORRECTION: The administrator could in-service employees who do cleaning of ovens and kitchen equipment on the need to keep it clean and sanitary.	21685		

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21685	Continued From page 43 TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21685		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to promote a dignified dining experience in the secured unit (Memory Lane) for 8 of 16 residents (R66, R63, R65, R38, R37, R73, R82 and R56) observed during a meal. Findings include: R66 was not assisted to eat while other residents at the table ate independently and when assisted to eat the food was not checked for warmth as it sat in the food cart and in front of R66 for a total of 37 minutes. R66 was admitted 6/24/2011 with a diagnosis of dementia, hallucinations, dementia with behavioral disturbance, esophageal reflux, legal blindness, panic disorder and depressive disorder. A Quarterly Minimum Data Set assessment dated 8/12/2013 identified R66 as severely cognitively impaired and required extensive assist of one for eating. On 11/4/2013 12:12 p.m., the food cart arrived in	21805		

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the unit from kitchen. At 12:35 p.m., R66 received their food tray which had been uncovered. There were three other residents at this table and all three began to eat as soon as the meal was provided. R66 just watched the others eat until R66 picked up a plastic covered piece of bread and started chewing on it as the nurse had not removed the plastic from the sandwich when meal was set before R66. After the nurse had removed the plastic from the sandwich R66 make no attempt to eat independently. At 12:42 p.m., nurse manger (NM)-A sat next to R66 and began to assist R66 to eat. However, the food that had been delivered thirty minutes ago and sat uncovered for seven minutes was not warmed for the resident.

On 11/6/2013, food trays arrived at 11:55 a.m. in the unit, R66 again received a tray uncovered 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 nursing assistant (NA)-F sat next to R66 at 12:43 p.m. Again the food sat on the table uncovered for 28 minutes and had been in the food cart for 20 minutes prior to being set in front of R66. On questioning NA-F at 12:43 in regards to the food being cool NA-F said that she felt the food was still warm and made no attempt to test the food for temperature or warm the food for R66.

R63 was not 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.
Admitted: 5/6/2011 with diagnoses this included but not limited to: senile dementia.
A quarterly MDS dated 9/6/2013 identified resident as severely cognitively impaired and

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required supervision and cueing after set up of meal.
On 11/6/2013 at 11:55 a.m., the food cart had arrived from the kitchen. The menu was Tater Tot Hotdish, rutabagas and chocolate chip dessert. At 12:15 p.m., R63 received a meal tray that had been uncovered. 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 R63 to eat the meal when it was set in front of her or to use a fork to eat the cake. R63 began 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 warm at the time R63 began to eat the foods. During the entire meal service for R63 there was a nursing assistant seated at the same table helping R37 to eat their meal.

R65 had been observed to not wear lower denture during meal and no staff attempted to encourage her to do so. R65 held the denture in her hand while attempting to use fork with the same hand.

R65 had diagnoses which included: senile dementia, altered mental status and depressive disorder.

R65's annual MDS assessment dated 10/11/2013 identified R65 as severely cognitively impaired and required supervision and cueing of one staff for eating.

On 11/6/2013 at 11:55 a.m., the food cart arrived to the dining area of memory lane. The menu was Tater tot Hotdish and rutabagas and

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chocolate chip dessert. At 12:01 p.m. R65 received a food tray of regular textured food. The resident used a fork and started to eat with the left hand. The resident was observed to be clutching their lower dentures in the left hand while holding the fork to eat. At 12:12 p.m., R65 started eating the cake using her fingers. At 12:21 p.m., R65 use her fingers to remove some of the cake she just put into her mouth and placed it back in the bowl. At 12:27 p.m., R65 was done eating and was still holding the bottom dentures which she had during the entire meal. During the entire meal for R65 no staff encouraged her to use her bottom denture to eat the meal nor had they encouraged her to use the fork to eat the foods provided. R65 was not noted to have a problem with coughing while eating the few bites of food she took.

On 11/7/2013 at 8:30 a.m., a licensed practical nurse (LPN)-D was interviewed regarding R65 ' s not using the bottom dentures while eating the meal on 11/6/13 at noon. LPN-D indicated R65 would take dentures out of mouth and put them in when the resident wanted. LPN-D said that staff is to encourage R65 to wear dentures while eating. R65 was observed at 8:30 to be eating while holding denture in her left hand. After informing LPN-D of R65 holding onto denture LPN-D approached R65 and asked her put her denture back in her mouth. R65 nodded yes and LPN-D put the denture in R65 ' s mouth and R65 made no attempt to remove the denture for the rest of the meal.
R38 was not assisted during dining in a timely manner.
A quarterly minimum data set assessment dated 10/6/2013 identified resident as severely cognitively impaired and required limited assist of one staff for eating. The resident had diagnoses

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which included: Alzheimer's dementia, aphasia, and depression.
On 11/4/2013 at 12:12 p.m., the food cart arrived on memory lane unit from the kitchen.
At 12:25 p.m., R 38 was given a tray of food uncovered and the resident started playing with the bib in the food. The resident made no attempt to eat and no staff assisted the resident. At 12:42 p.m., a nurse manger (NM)-A sat down by R38 and assisted the resident to eat. The resident ' s food sat on the food cart for 13 minutes and then sat on the table another 17 minutes before the resident was fed or assisted to start to eat. During that time, the resident continued to play with the bib in the food. Other residents at the table were eating.

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.

A quarterly MDS dated 9/5/2013 identified the resident as moderately cognitively impaired and required supervision and cueing of one staff for eating. Diagnoses included: malnutrition, depression, dementia, and stroke.

On 11/6/2013 at 11:55 a.m., the food cart arrived in the memory lane unit. R37 received a meal tray of food uncovered at 12:07 p.m. R37 was observed to be asleep in the wheelchair when the food arrived. NA-C went over to cue R37 to eat a couple of times, but the resident would doze off as soon as NA-C left. At 12:28 p.m., NA-C sat next to R37 and began to assist R37 to eat. This was 33 minutes after the food trays arrived in the unit and 21 minutes after R37 ' s food was placed uncovered in front of her. NA-C had not checked

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the food for temperatures and made no attempt to warm the foods.

R73 was not assisted in a timely manner during dining.

On 11/4/2013 at 12:12 p.m., the food cart arrived on the memory lane unit from the kitchen. At 12:42 p.m., R73 had a tray of food put in front of her and it was uncovered. The food had been in the food cart for thirty minutes and had not been checked for temperature before serving to R73.

During dining observation on 11/4/2013 from 12:12 p.m. until 12:45 p.m., R73 was in a wheelchair with lap buddy on wheeling self around the dining room as other residents were eating or waiting to be assisted to eat. R73 was singing loudly and for long periods of time until she was assisted to a table and encouraged to eat her meal at 12/42 p.m. During this time R82 was yelling at R73 to " Shut up! Shut up! " Then R56 would add to the yelling by saying, " Hello! Hello! " then R56 used her spoon to pound it loudly on the table. There were no staff interventions for any of these disruptive behaviors from residents making an unpleasant and disruptive dining experience for 16 of the 17 residents living on the unit as one resident at in the privacy of their bedroom. It was also observed at the start of the meal that no resident had their hands washed even though several had used their fingers to eat their foods.

On 11/4/2013 at 1:45 p.m. and again on 11/7/2013 at 9:00 a.m., LPN-D was interviewed regarding dining observations on 11/4/13 at noon. LPN-D stated it had been normal for some of the

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21805	Continued From page 49 residents to wait to eat because of the short staffing. LPN-D said that they usually staffed one nursing assistant and one nurse during the day shift for 17 residents who needed quite a bit of assistance. The residents are assisted to eat as soon as they can get around to them and the food is not always reheated for the residents who sat a long time waiting to be assisted to eat. LPN-D said that the staff wasn ' t always able to cue the residents as they should have been to eat their meal or to be able to monitor behaviors closely during dining because it was too busy during the dining meal to just get residents assisted to eat. SUGGESTED METHOD OF CORRECTION: The administrator, director or nursing or designee could provide staff education related to dignified dining services and monitor for compliance TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21805		